

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Frederick <del>XX</del> TALBOT Nelson		2a. DATE OF DEATH MONTH DAY YEAR 4 19 82		2b. HOUR 11:05A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. Charles Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Construction Equipment	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS 918 Southerly Road 21204			
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Nelson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Shelly		ADDRESS Rd. Shelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mrs. Nancy Ellicott Nelson		ADDRESS 918 Southerly	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse Vascular Disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>04/18</u> , 19 <u>82</u> , to <u>04/19</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>04/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Ricely, M.D.		22e. ADDRESS GBMC 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21 APR 82		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Monkton, Maryland	
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon Padonia & York Road				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 21 1982 Frances Jan Nether			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 6 5

REG. NO.

FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
George Melvin NEWMAN			April 15, 1982			4:00 a		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS [LAST BIRTHDAY])			IF UNDER 1 YEAR		
M	W	1/17/06	76 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
TENN.	USA				Baltimore County MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
ROSSVILLE	FRANKLIN SQ.			WIRE				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
M D.			BALTO			MIDDLE RIVER		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
JOHN NEWMAN			LULA PENDERGRAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
UNK			223-26-4871			MARY NEWMAN ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4299</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>End stage Chronic Obstructive Pulmonary Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>End Stage Heart Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 16,</u> 19 <u>82</u> to <u>April 15</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 15</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (view) the body after death.								
22b. SIGNATURE <u>Steve Waters</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-15-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steve Waters M.D.					22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		4/17/82		HOLLY HILL		BALTO. MD		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
J.B. CONNELLY 300 MACE					APR 21 1982 [Signature]			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH ESTI MATED		MONTH		DAY		YEAR		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Rita		M		Norris				April 3 1982		April 3 1982													
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Female	White	Oct 23, 1919		62 YRS.						April 3 1982								Baltimore County					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.													
Maryland		U.S.A.						Baltimore County															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Towson		St Joseph Hospital		Accounts Payable Clerk																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland		Baltimore		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8303 Oakleigh Rd															
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																					
William		Carmela																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
No		213-16-3759		Mr Clarence G Norris		Same																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:																					
4100		IMMEDIATE CAUSE (a)		Cardiac Arrest																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		Acute Myocardial Infarction																			
		(c)		Generalized Aneurysm																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																					
20. AUTOPSY?																							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
		HOUR A.M. MONTH DAY YEAR																					
		P.M. 19																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																			
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion															
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Charles F O'Donnell M.D.		TITLE (SPECIFY)		Deputy		MEDICAL EXAMINER		DATE SIGNED		4/3/82											
EXAMINER'S NAME (TYPE OR PRINT)		Charles F O'Donnell M.D.		ADDRESS		7501 York Rd		Towson, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																	
Burial		4/7/82		Dulaney Valley		Baltimore, Maryland																	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Leonard J Ruck Inc.		Baltimore, Maryland				APR 5 1982		Name															



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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 0 8 7 6 7	
1- STATE REGISTRAR		XC 26 148 993	
FOR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST WILLIAM S. NOWAKOWSKI		MONTH DAY YEAR 4 30 82	
3. SEX MALE		7b. HOUR 2:52A <sub>M</sub>	
4. RACE WHITE		5. DATE OF BIRTH	
6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
59 YRS.		MARYLAND	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH FORT HOWARD		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V. A. MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CORRECTIONAL OFFICER	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	
13c. CITY OR TOWN FORT HOWARD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. NOWAKOWSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA HAJAWSKI	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216 16 8050	
16c. IF YES, GIVE WAR OR DATES WWII		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF ACUTE MYOCARDIAL INFARCTION WITH CARDIOGENIC SHOCK (b) <u>70 MINS.</u> DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE (c) <u>10 YEARS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 MINS. 70 MINS. 10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE - OTHER EVIDENCE OF VASCULAR DISEASE IS STROKE, BILATERAL AKHS			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/9</u> 19 <u>78</u> , to <u>4/30</u> 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>4/30</u> 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.			
22b. SIGNATURE <u>Wen Shyang Wu M.D.</u>		22c. DATE SIGNED 4/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WEN-SHYANG WU, M. D.		22e. ADDRESS V. A. M. C., FORT HOWARD, MARYLAND 21052	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/3/82	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 3 1982	
25b. REGISTRAR'S SIGNATURE <u>James J. Smith</u>			

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Items, 2a. & 2b., G-568, 6/9/82  
FOR  
STATE  
REGISTRAR  
by F.H.D., Gbj.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>WILLIAM J NUGENT</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>APRIL 13 1982</u> 2b. HOUR <u>11:30</u> M		
3 SEX <u>MALE</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>JULY 2 1909</u>	6 AGE (IN YEARS LAST BIRTHDAY) <u>77</u>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MASS</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE</u> COUNTY MD.		
10 CITY OR TOWN OF DEATH <u>BALTIMORE</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>317 A. SAVANNAH</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>SEAP</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>MD.</u>			13b. COUNTY <u>BALTO</u>	13c. CITY OR TOWN <u>ESSEX</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <u>WILLIAM B. NUGENT</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARY KELLY</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNK</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>012 106325</u>	17. INFORMANT ADDRESS <u>SUSAN REITER ABOVE</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF THE LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1982</u> to <u>April 13, 1982</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Lydia M. Jumanoy, M.D.</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LYDIA M. JUMANOY, M.D.</u>			22e. ADDRESS <u>CHURCH HOSPITAL; 100N BROADWAY; BALTO</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4/15/82</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORELANDS</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR NAME <u>Connelly F.H. 300</u>			25a. DATE REC'D. BY REGISTRAR <u>APR 21 1982</u>		
25b. REGISTRAR'S SIGNATURE <u>James J. Nathan</u>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 6 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Alvin</i>		FIRST MIDDLE LAST <i>OSBERENDER</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>APRIL 19 82</i>		2b. HOUR <i>7<sup>30</sup> A.M.</i>	
3. SEX <i>MALE</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>JAN 34 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Overlea Md</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12 E. Elm Ave 21206</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MOVING-Handling</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Transp.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>BALTO</i> 13c. CITY OR TOWN <i>Overlea</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Fredrich A. Osberender</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Augusta A. BATES</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>218306233</i>		17. INFORMANT ADDRESS <i>up. Burtis Osberender same.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Adeno Carcinoma</i> <i>1590</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adeno Carcinoma Bowel</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>undet.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months.</i>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Early</i> 19 <i>60</i> to <i>19 April</i> 19 <i>82</i> , that (s) (we) lost saw the deceased alive on <i>19 April</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (I did not) view the body after death.							
22b. SIGNATURE <i>John C. Hyle</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>4-19-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN C. HYLE MD</i>				22e. ADDRESS <i>7527 Belair Rd Ball's 21236 Md</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4-22-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Parkville Baltimore Md</i>	
24. FUNERAL DIRECTOR NAME <i>Lassahn Funeral Home</i>				25. ADDRESS <i>7401 Belair Rd</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 7 0

REG. NO.

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Francis X O'Done 11/5</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>04 05 82</b>		2b. HOUR <b>11:45</b> AM	
3. SEX <b>male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 16, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		# UNDER 1 YEAR MONTHS DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Kuxton Hsg. Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gov't.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b> COUNTY <b>BALTIMORE</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>5704 BEECHDALE AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John JOSEPH O'Donnell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY CECILIA HUGHES</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>705 07 9291</b>	
17. INFORMANT <b>FAMILY RECORDS</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cause of Lung Squamous Cell</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 82</b> to <b>April 05 82</b> , that (I) <del>first</del> last saw the deceased alive on <b>March 19 82</b> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>first</del> did not visit the body after death.		22b. SIGNATURE <b>Walter T. Kees</b>		22c. DATE SIGNED <b>5 April 1982</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. KEES</b>		22e. ADDRESS <b>Monkton Md 21111</b>		22f. MEDICAL EXAMINER ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-8-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>TIMONUM BALTO. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPL OF CHIMES</b>		24b. ADDRESS <b>2325 York Road</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 14 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Frances J. Hinton</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 / 7 / 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARNOLD GILLETTE OGDEN						2a. DATE OF DEATH MONTH DAY YEAR 4 24 82				2b. HOUR 4:20 PM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 26 96		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clarian PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.							
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGRAVER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T					
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Clarksville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11202 Johns Hopkins Rd					
14. FATHER'S NAME FIRST MIDDLE LAST John W OGDEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E UNKNOWN				16. ADDRESS LAUREL, MD. 20707					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWW-578-48-3297		17. INFORMANT SHIRLEY C. JAMES		7918 BELGARD ROAD							
18. CAUSE OF DEATH Enter only one cause per item (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ASHT doc, congestive ht. fail.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from <u>June 19 81</u> to <u>4/24 82</u> that (2) I last saw the deceased alive on <u>4/23 82</u> and that in my opinion death occurred on the date and hour and from the causes stated above. (If yes (did) not view the body after death.)													
23a. SIGNATURE C. S. MASS				23b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				23c. DATE SIGNED 4/24/82					
23d. PHYSICIAN'S NAME (TYPE OR PRINT)				23e. ADDRESS 43 Nottingham Rd. 21229									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-28-82		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD.							
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR APR 28 1982		25b. REGISTRAR'S SIGNATURE James Van Kester					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 7 7 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ONEILL, DOROTHY B.</b>			2a. DATE OF DEATH MONTH <b>April</b> DAY <b>28</b> YEAR <b>1982</b> HOUR <b>9:03</b> AM		
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>8</b> YEAR <b>1907</b>	6. AGE (IN YEARS (LAST BIRTHDAY)) <b>74</b>		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4329 Falls Road</b> <b>21211</b>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Herbert</b> LAST <b>Berry</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Rosa</b> MIDDLE <b>Caltrider</b> LAST <b>Caltrider</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 40 4060</b>		17. INFORMANT ADDRESS <b>Thomas Ward</b> <b>848 W. 36th Str.</b> <b>21211</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardiovascular Disease</b> (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>Atherosclerotic Cardiovascular Disease</b> (c) <b>Atherosclerotic Cardiovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>3 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>APRIL 28 1982</b> to <b>APRIL 28 1982</b> , that (1) (we) last saw the deceased alive on <b>APRIL 28 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If burial (did) (did not) view the body after death.					
22b. SIGNATURE <b>Walter R. Welzant</b> M.D.		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>28 APRIL 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter R. Welzant M.D.</b>		22e. ADDRESS <b>St. Joseph Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 1, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Pikesville</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 30 1982</b>			
24. FUNERAL DIRECTOR <b>Bungee Funeral Home</b> <b>3631 Falls Rd.</b> <b>21211</b>		25. REGISTRAR'S SIGNATURE <b>James J. Smith</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 7 7 3			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BLANCHE W. ORTH</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>April 30, 1982</b>				2b. HOUR <b>10:30A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 31, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Lutherville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>214 Ridgley Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>214 Ridgley Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles E. Wingate</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Kemp</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>157-30-1758A</b>		17. INFORMANT <b>Mr. Henry Orth</b>		ADDRESS <b>same as # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Breast carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1976</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 31</b> , 19 <b>80</b> , to <b>April 30</b> , 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>April 28</b> , 19 <b>82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>Donald O. Wood</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Apr. 30, 1982</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald O. Wood M.D.</b>						22e. ADDRESS <b>2 Greenmeadow Drive</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>May 1, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1982</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 8 7 7 4			
1 - FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna L. Otten						2a. DATE OF DEATH MONTH DAY YEAR April 17, 1982				2b. HOUR 7 P M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH July 8, 1884 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 97		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7812 Oak Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7812 Oak Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST Peter Lentz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-2714		17. INFORMANT ADDRESS Mr. Raymond L. Otten same									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atherosclerotic Cardiovascular Disease</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION <u>X</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> 19 <u>79</u> to <u>4-17</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4-17</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) view the body after death.													
22b. SIGNATURE <u>John C. Hyle</u>				DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4-19-82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Hyle, M.D.				22e. ADDRESS 7527 Belair Road Baltimore, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 20, 1982		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR APR 19 1982		25b. REGISTRAR'S SIGNATURE <u>James Van Nuthan</u>							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK A. PALMISANO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 6, 1982</b>		2b. HOUR <b>7:25 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 22, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>B. G. G. H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Produce Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Owings Mills</b>	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>20 C. Deer Lodge Court</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Palmisano</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1943</b>		17. INFORMANT ADDRESS <b>Mrs. Belle R. Palmisano Owings Mills, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4254 IMMEDIATE CAUSE (a) Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>History of Anterior Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>April 6, 1982</b> to <b>April 6, 1982</b> . I saw the deceased alive on <b>April 6, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <b>Harry E. Newman</b>				22c. DATE SIGNED <b>4/06/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 9, 82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Eline Funeral Home Reisterstown, Md. 21136</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 8 1982</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1570

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 0 8 1 7 6	
1. DECEASED NAME (TYPE OR PRINT) <b>SHELTON D. PARKER</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. <b>4 9 19 82 6 15</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>26</b> YEAR <b>26</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>55</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>9</b> YEAR <b>19 82</b>	2d. HOUR <b>6 15</b>		2e. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>9</b> YEAR <b>19 82</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Lansdowne</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2608 Myrtle Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shop Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wm. A. Harting &amp; Son Const.</b>			
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>2608 Myrtle Avenue 21227</b>			
14. FATHER'S NAME FIRST <b>Lester</b> MIDDLE <b>Parker</b> LAST <b>Parker</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elenor</b> MIDDLE <b>Beasley</b> LAST <b>Beasley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>216-20-8806</b>		17. INFORMANT ADDRESS <b>21227 Mary Gladys Parker 2608 Myrtle Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD.</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. P. Williamson II</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER		DATE SIGNED <b>4/19/82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>E. P. Williamson II</b>				ADDRESS <b>5550 BALTO NAT'L PK. 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>				23d. LOCATION CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>				25. DATE REC'D. BY REGISTRAR <b>APR 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					

0 1 1 0 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, Boston, MA; 789 Oak Street, Chicago, IL; 101 Pine Street, Philadelphia, PA; and 202 Cedar Street, San Francisco, CA.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, Boston, MA; 789 Oak Street, Chicago, IL; 101 Pine Street, Philadelphia, PA; and 202 Cedar Street, San Francisco, CA.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, Boston, MA; 789 Oak Street, Chicago, IL; 101 Pine Street, Philadelphia, PA; and 202 Cedar Street, San Francisco, CA.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, Boston, MA; 789 Oak Street, Chicago, IL; 101 Pine Street, Philadelphia, PA; and 202 Cedar Street, San Francisco, CA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 7 7 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Catherine Parks</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 13 1982</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 10 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perring Pkwy Nursing Home.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis T Heying</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Franz</b>		13e. STREET ADDRESS <b>3004 Evergreen Ave</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-34-4482</b>		17. INFORMANT ADDRESS <b>Mr J. Leo Parks Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alzheimer's Disease</b> <b>3310</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASA-CVD</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital attended the deceased from <b>April 1 1982</b> to <b>April 13 1982</b> , that (I) (we) last saw the deceased alive on <b>April 1 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) sign the body after death.							
22b. SIGNATURE <b>Donald W. Mintzer MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/13/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald W. Mintzer</b>		22e. ADDRESS <b>3009 Evergreen Ave Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/16/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 16 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 7 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR MIN	
Winfred L. PARSONS		4-4-82		10:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
FEMALE	White	MONTH DAY YEAR	77 YRS	Baltimore County MD	
		July 16 1904			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
ALTOONA, PA	U.S.A.		Packer		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY		12c. KIND OF BUSINESS OR INDUSTRY	
REGISTERSTOWN	BENT NSG. HOME	Bakery		Bakery	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD	Baltimore	Lansdowne	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3313 Bero Rd. 21227	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT ADDRESS			
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
George Troy	Sarah Vincent				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS			
NO	220-20-0726	Kathleen Scheitlin (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) Chronic Obstructive Lung Disease					
4960 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure due to atherosclerosis					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-26-1982 to 4-4-1982, that (I) (we) last saw the deceased alive on 4-2-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE		27c. ADDRESS		27d. DATE SIGNED	
C.E. McWilliams MD		11954 Registerstown Rd Registerstown Md. 21136		4-4-82	
27e. PHYSICIAN'S NAME (TYPE OR PRINT)		27f. ADDRESS		27g. DATE SIGNED	
C.E. McWilliams		11954 Registerstown Rd Registerstown Md. 21136		4-4-82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/7/1982		Glen Haven Memorial	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
George J. Gonc. F.H.		4001 Ritchie Hgwy.		APR 8 1982	
24c. ADDRESS		24d. ADDRESS		25b. REGISTRAR'S SIGNATURE	
Balto., Md. 21225		Baltimore, Md.		James J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 7 7 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen R. Pavlik</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>4-20-82</i>		2b. HOUR <i>7 A. M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1-19-1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>							
10. CITY OR TOWN OF DEATH <i>Dundalk</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3133 Yorkway</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Dundalk</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3133 Yorkway</i>		21222			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Bykowski</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Petrovich</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>169-05-33280</i>		17. INFORMANT ADDRESS <i>Mrs. Dolores M. Garrett - 3133 Yorkway 21222</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>atherosclerotic heart disease</i> (c) <i>COPD</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY/TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from <i>12/01</i> 19 <i>80</i> to <i>4/17</i> 19 <i>82</i> that (I) (we) last saw the deceased alive on <i>4/17</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) visit the body after death.										22a. DATE SIGNED <i>4/20/82</i>			
22b. SIGNATURE <i>Ernest N. Arnett, M.D.</i>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ernest N. Arnett, M.D.</i>				22e. ADDRESS <i>9101 Franklin Square Dr. Suite 214 Baltimore, Maryland 21237</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>4-21-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>		23d. LOCATION CITY/TOWN COUNTY STATE <i>Balto. Md.</i>							
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 22 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 / 8 0 REG. NO.					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ralph Arlington Payette										April 28, 1982		2 P.		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS.					
Male		White		Dec. 13, 1912		69 YRS.		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.									
10 CITY OR TOWN OF DEATH Reisterstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 40 Hanover Rd.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		40 Hanover Road							
14. FATHER'S NAME FIRST MIDDLE LAST Louis Payette					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Sherman										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) 1934-1957		17 INFORMANT Mrs. Bertha M. Payette		ADDRESS Reisterstown, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal Carcinoma - primary 1952 DUE TO, OR AS A CONSEQUENCE OF (b) site unknown DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 1980, to April 28 1982, that (I) (we) last saw the deceased alive on April 26 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE C.E. McWilliams M.D.								DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-29-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams M.D.								22e. ADDRESS 11904 Reisterstown Rd Reisterstown Md 21136							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE May 1, 82		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24 FUNERAL DIRECTOR NAME Eline Funeral Home								ADDRESS Reisterstown, Md. 21136		25a. DATE REC'D. BY REGISTRAR APR 30 1982					
								25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]							

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Robert M. Johnson

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 7 8 1 REG. NO.			
1 - STATE REGISTRAR FOR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas W. Pero				2b. HOUR 9:20a M			
3 SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11/29/17		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SOAP		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.				13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN PERO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA MURPHY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 030 01 8413		17. INFORMANT CLAIRE PERO		ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Duodenal Ulceration with Gastrointestinal Hemorrhage 1629 (b) Carcinoma of Lung with Liver Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from April 9, 19 82, to April 23, 19 82, that (we) lost saw the deceased alive on April 23, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Richter M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Richter M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/26/82		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR APR 28 1982	
				25b. REGISTRAR'S SIGNATURE James J. Richter			

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LIBRARY OF THE  
BOSTON PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION  
100 NASSAU ST. N.Y.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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21 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 8 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BENJAMIN H. PETERSON			2a. DATE OF DEATH April 20, 1982		2b. HOUR 4:30a M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11/1/88		6. AGE (IN YEARS LAST BIRTHDAY) 93	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	
13a. STATE MD		13b. COUNTY BALTO.	13c. CITY OR TOWN WHITE MARSH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 18720 GRAYSTONE RD
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL PETERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANCY WHITSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 237561950		17. INFORMANT ADDRESS ELIZABETH PETERSON ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest; Congestive Heart Failure 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pneumonitis; Urinary Tract Infection					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 15, 1982, to April 20, 1982, that <input checked="" type="checkbox"/> (we) lost <input checked="" type="checkbox"/> saw the deceased alive on April 20, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE J. E. ERNANDEZ		DEGREE		22c. DATE SIGNED 4/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. E. ERNANDEZ		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/24/82	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME J. G. CONNELLY		ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR APR 21 1982	25b. REGISTRAR'S SIGNATURE James J. Nathan

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 8 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Victoria Pietruczewski		2a. DATE OF DEATH MONTH DAY YEAR 04 10-82		2b. HOUR 2:50 A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 10 87		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.	
10. CITY OR TOWN OF DEATH Balto. Co.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bent Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cannery Packer		12b. KIND OF BUSINESS OR INDUSTRY Cannery
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md 13b. COUNTY Balto 13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12020 Reisterstown Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-07-4736		17. INFORMANT ADDRESS Andrea Elliott 5110 Dickeyville Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Congestive Heart Failure - Chronic, 4 years DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, 10 years DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-20 1976, to 4-10 1982, that (I) (we) last saw the deceased alive on 4-5 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C.E. McWilliams M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams M.D.		22e. ADDRESS 11904 Reisterstown Rd Reisterstown Md. 21136			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4-13-82	23c. NAME OF CEMETERY OR CREMATORY Holy Robery Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME JOHN M. WIEBER & SONS		ADDRESS 401 S. CHESTER ST.		25a. DATE REC'D BY REGISTRAR APR 14 1982	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes, possibly a list or ledger, with some numbers and text. The text is mostly illegible due to fading and bleed-through.

Handwritten notes, possibly a list or ledger, with some numbers and text. The text is mostly illegible due to fading and bleed-through.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 8 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA E. PINKSTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 20, 1982</b>		2b. HOUR MIN <b>12:35p</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 8 1925</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>57</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH <b>Rossville 2137</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Franklin Sq. Hospital</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
12a USUAL OCCUPATION (TYPE OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>		MD.		
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Essex 21221</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Dehner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irymanta Boughn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217 22 7289</b>		17 INFORMANT ADDRESS <b>William E. Pinkston Husband</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5728</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hepatic Failure</b> (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 10</b> , 19 <b>82</b> , to <b>April 20</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 20</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Richard Del Pero</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/20/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Del Pero</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>				
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>4/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dehner Family Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Montplier, Va.</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 23 1982</b>		23f. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		
24. FUNERAL DIRECTOR <i>Bozdinski Funeral Home</i> PA 1407 Old Eastern Ave						

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

1912



TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY,  
WASHINGTON, D. C.  
FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY,  
WASHINGTON, D. C.  
SUBJECT: [Illegible]

[Extremely faint and illegible body text, possibly containing a list or detailed report.]

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the registrars, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar in other death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 / 8 5			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ella May Pissakas</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 9 1982</b>		2b. HOUR M <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 30 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>60</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1710 Dundalk Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Wissmann</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella - - - -</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-18-1302</b>		17. INFORMANT ADDRESS <b>Nicholas Pissakas - Balto. MD 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cord stroke</u> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/7/82</u> 19 <u>82</u> to <u>4/9/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/9/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. George Dendrinos</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/9/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. George Dendrinos</b>				22e. ADDRESS <b>5113 Eastern Avenue, Baltimore, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 13 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i>	
7922 Wise Avenue, Dundalk, Maryland 21222							



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 8 6  
REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDNA M. PITTINGER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Apr. 4, 1982</b>		2b. HOUR <b>4:40</b> M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 23 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt County</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>1500 E. Gappa Rd. 21204</b>	
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland Baltimore Catonsville</b>	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <b>224 Westshire Road</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph S. Robinson</b>	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie V. Wigginton</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-05-2954</b>	
17. INFORMANT ADDRESS <b>Mr. Wilbur H. Robinson 224 Westshire Road</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>over 598</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>over 598</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>8 February 1978</b> , to <b>4 April 1982</b> , that (I) (we) last saw the deceased alive on <b>2 April 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Walter T. Hicks</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. HICKS</b>		22e. ADDRESS <b>Montclair MD 21111</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-6-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James Episcopal Church</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Monkton, Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 5 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 7 8 7					
1. FOR STATE REGISTRAR		2a. DATE OF DEATH								2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH								2b. HOUR					
FIRST MIDDLE LAST ANNA M BLUMER ANNA M BLUMER		4-14-82								12:42p <sub>M</sub>					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		OCTOBER 1, 1899				82 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA						BALTIMORE COUNTY MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		ST. JOSEPH HOSPITAL										HOMEMAKER			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
MD.				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				422 OVERBROOK RD.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST JOSEPH LACY				FIRST MIDDLE LAST MARGARET GOLDEN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
NO				213-74-3991				EDWARD F. PLUMER 422 OVERBROOK RD. 21212							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))										ACUTE CONGESTIVE HEART FAILURE					
4292										ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Arteriosclerotic Cardiovascular Disease					
										(c) Due to, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										ADENOCARCINOMA OF THE COLON					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-8 19 82 to 4-14 19 82, that (I/we) last saw the deceased alive on 4-14 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.															
22b. SIGNATURE										22c. DATE SIGNED					
Beatriz P. Dizon, M.D.										4/14/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
BEATRIZ DIZON, M.D.										7620 YORK ROAD TOWSON M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				APR. 17, 1982				PARKWOOD CEM.				PARKVILLE BALTO. MD.			
24. FUNERAL DIRECTOR										25. DATE REC'D BY REGISTRAR					
NAME ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212										APR 19 1982					

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UNITED STATES DEPARTMENT OF THE INTERIOR

TO THE SECRETARY OF THE INTERIOR  
FROM THE COMMISSIONER OF THE GENERAL LAND OFFICE  
SUBJECT: [Illegible]  
[Illegible text follows]

UNITED STATES DEPARTMENT OF THE INTERIOR

[Illegible handwritten text]

RECEIVED  
[Illegible stamp and text]



APR 1 1902  
[Illegible text]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 8 8

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		ALEXANDER WILSON PLUMMER		4 - 22 - 82		6:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Male		White		8 11 1915		66	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA				Baltimore County, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk		Heritage Nursing Center		Welder		Beth. Steel	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
MD		Baltimore		Dundalk		2621 Liberty Pky.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Stephen		Jeston		No			
17a. SOCIAL SECURITY NO.		17b. INFORMANT		17c. ADDRESS			
227-03-7683		Shirley R. Plummer		2621 Liberty Parkway Balto. MD 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Carcinoma of colon							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
ASCVD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from July 4-12 19 67 to 4-22 19 82 that (2) we last saw the deceased alive on 4-12 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
WYMAN K. WONG		M.D.		APR 26 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
WYMAN K. WONG		6730 Holabird Ave.		21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		4/26/82		Holly Hill Memorial		White Marsh, Baltimore MD	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR			
Duda-Ruck, Inc.		7922 Wise Avenue, Dundalk, MD 21222		APR 26 1982			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits require carbon copies. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 0 8 7 8 9							
1- STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Poklis</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>4 2 1982</b>		2b. HOUR <b>1445</b>									
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 5 17</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>65</b>	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 2 1982</b>		2d. HOUR <b>1600</b>											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.													
10. CITY OR TOWN OF DEATH <b>Edgemere</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2107 Lodge Forest Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth.Steel</b>											
13a. STATE <b>Maryland</b>												13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2107 Lodge Forest Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Poklis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Sharkey</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>215-07-4697</b>		17. INFORMANT <b>John M. Poklis</b>		2208 Lodge Forest Drive Balto., MD. 21219											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic ischemic myocardial disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Diabetes mellitus</b>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>		TITLE (SPECIFY) <b>Deputy</b>		M.D. _____		MEDICAL EXAMINER		DATE SIGNED <b>4/5/82</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. J. Crossan O'Donovan</b>		ADDRESS <b>2112 Dundalk Avenue</b>		21222															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/5/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>													
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 5 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>													

1880

STATE OF NEW YORK  
IN SENATE  
January 12, 1880

REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 18, 1879  
AND  
BY THE ASSEMBLY  
JANUARY 12, 1880  
ALBANY:  
J. B. LEECH, PRINTER.  
1880.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 9 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pinkie M. Pollard			2a. DATE OF DEATH MONTH DAY YEAR 4-27-82		2b. HOUR M
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 1 17 86		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1006 Alexander Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Catonsville	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edmond Holmes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Ann Holmes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Eugene Ward 1006 Alexander Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C.V.A. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE CVD (c) ARTERIOSCLEROTIC CVD DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK. 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/15, 19 82, to 4/27, 19 82; that (I) (we) lost saw the deceased alive on 4/26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Norman R. Keiman		DEGREE MD		22c. DATE SIGNED 4/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN R. KEIMAN		22e. ADDRESS 3803 Edmondson Ave - BALTO MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/1/82	23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.
24. FUNERAL DIRECTOR NAME Chas. H. Powell		F/H 319 N. Schroeder St.		25a. DATE REC'D. BY REGISTRAR MAY 4 1982	
				25b. REGISTRAR'S SIGNATURE Francis J. Nathan	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08791	
1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS PONENTO</b>										2a. DATE KNOWN OF DEATH EST. MATED <b>April 23 1982</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 5, '18</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>63</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>April 23 1982</b>		2b. HOUR <b>10:45 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Parkton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>19111 Middletown Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retailer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sporting Goods</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1504 Taylor Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pasquale Ponento</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Deromedi</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-16-9187</b>		17. INFORMANT ADDRESS <b>Gail M. Price 7210 Sindall Rd. 21234</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ASCD with Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2+ yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 26, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>William E. Johnson 8521 Loch Raven Blvd.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Nathan</b>					



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 7 9 2  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Anna K. Powers</b>			2a DATE OF DEATH MONTH DAY YEAR <b>April 4, 1982</b>		2b HOUR M
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 19, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10 CITY OR TOWN OF DEATH <b>Essex</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>503 N. Stuart St.</b>		12a USUAL OCCUPATION (1900S OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>	12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Sparrows Point</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS <b>9012 Ave B 21219</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Peter Lauer</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Wierel</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>	17 INFORMANT ADDRESS <b>503 N. Stuart St. Baltimore, Md. 21221</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Ovarian Cancer.</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110					
19a DATE OF OPERATION <b>9/22/81.</b>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pelvic mass with uterine prolapse.</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>9/20/1981</b> to <b>9/30/1982</b> . saw the deceased alive on <b>1/14/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>G. Patel</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>4/6/82.</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEETA S. PATEL.</b>		22e ADDRESS <b>9101, Franklin Square Drive Baltimore - 21237.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>4-7-82</b>	23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>		
24. FUNERAL HOME <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave</b>		25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>APR 6 1982</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24  
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>AGNES ELIZABETH PRENTICE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 22 1982</b>			2b. HOUR <b>4:50P M</b>			
3. SEX <b>female</b>		4. RACE <b>W hite</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 05 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY - - - - -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Lutherville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS <b>2419 Chetwood Circle 21093</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Somerset Dyson Roby, Jr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Elizabeth Stone</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217 01 1295</b>		17. INFORMANT ADDRESS <b>Mr. Willard J. Prentice 2419 Chetwood Circle</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5700</b> IMMEDIATE CAUSE (a) <b>Acute hepatic necrosis, cause undetermined</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic ulcerative colitis</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/9</b> , 19 <b>82</b> , to <b>4/22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John E. Adams</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>4/23/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John E. Adams, M.D.</b>					22e. ADDRESS <b>6701 N. Charles St, Towson, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>26 APR 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Ceme</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Martin D. Lawson Padonia &amp; York Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 26 1982</b> 25b. REGISTRAR'S SIGNATURE <i>Thomas J. Smith</i>				

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RECEIVED

APR 11 1968

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 4/11/68

CLASSIFICATION: [illegible]

EXTENSION: [illegible]

REMARKS: [illegible]

ADMINISTRATIVE: [illegible]

APPROVED: [illegible]

SPECIAL AGENT IN CHARGE

NEW YORK

TELETYPE UNIT

TELEPHONE UNIT

MAIL ROOM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

Items 2a., 2b. File # <b>G567</b> STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. <b>08794</b>									
1. DECEASED NAME (TYPE OR PRINT) <b>April Lynn Price</b>										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> <b>3 29 19 82</b> ? M									
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/2/1961</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>21</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 10 1982</b> 7:34 P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>									
10. CITY OR TOWN OF DEATH <b>BALTO</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Loch Raven Fishing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE <b>MD</b>		13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1305 BELMONT AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM RONNIE PRICE</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIAN B. WEBSTER</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>WILLIAM RONNIE PRICE SEE #13</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation</b> 9630 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject strangled</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>wooded area</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Loch Raven Fishing Center. Balto., MD.</b>											
22a. I certify that I had charge of the remains described above, held of death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Thomas D. Smith</i> M.D. <b>Deputy Chief</b> MEDICAL EXAMINER										DATE SIGNED <b>4/11/82</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b> ADDRESS <b>111 Penn St. Balto., MD.</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>				23b. DATE <b>4/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DELMARVA CREMATORY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>LEWES, DEL.</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>WILSON FUNERAL HOME SALISBURY, MD.</b>										25a. DATE REC'D. BY REGISTRAR <b>APR 16 1982</b> REGISTRAR'S SIGNATURE <i>Thomas D. Smith</i>									

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 8 7 9 5

1- STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE
SCOTT		L.	PRYOR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)
Male	White	Mar 14 1956	26 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Maryland		U. S. A.	Baltimore City or County of DEATH
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK (MOST OF WORKING LIFE))
Balto. City 21237		9208 Oswald Way	Dealer Furniture
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS
Md		Carroll	Hampstead
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Robert L. Pryor		Elizabeth M. Snyder	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO			
17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Elizabeth Pryor		3992 Maple Grove Ad	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Thomas D. Smith		M.D. Deputy Chief MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Thomas D. Smith, M.D.		4-27-82	
ADDRESS		111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
Burial		4/30/82	St David's Cemetery
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
H. J. Eckhardt		MAY 4 1982	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
Manchester, Md.		Anne Gantman	

07-8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 12a, 12b g567 5/7/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Claude Richard PYNE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 30, 1982</b>		2b. HOUR <b>1:47<sup>a</sup> M</b>	
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 02 05</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>76</b>		
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>ROSEDALE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES E. PYNE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MOLLIE GIBBS</b>		12b. KIND OF BUSINESS OR INDUSTRY (17. <del>DEPARTMENT OF WORKING LIFE</del> ) <b>SALESMAN</b> <b>HARDWARE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213095957</b>		17. INFORMANT ADDRESS <b>MARIAN ARMIGER 405 OLD HOME RD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure, Pulmonary Infection</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 21</b> , 19 <b>82</b> , to <b>April 30</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 30</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.						
22b. SIGNATURE <i>Chris Berchelman</i>				22c. DATE SIGNED <b>5/30/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Chris Berchelman</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM.</b>		
24. FUNERAL DIRECTOR <i>John Walsh</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO BALTON MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1982</b>		

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DEPARTMENT OF THE ARMY

10-1-40

OFFICE OF THE ADJUTANT GENERAL

HEADQUARTERS, DEPARTMENT OF THE ARMY

WASHINGTON, D. C.

ADJUTANT GENERAL'S OFFICE



10-1-40

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 9 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HANNAH QUASH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 19, 1982</b>		2b. HOUR <b>5:35PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>10-30-1899</b> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>RANDALLSTOWN CONVAL CENTER</b>		12a. USUAL OCCUPATION (IF NOT OF WORKING AGE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>RANDALLSTOWN</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>9837 TOLLWORTH CIRCLE (21133)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS SHAPIRO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-74-1236</b>		17. INFORMANT ADDRESS <b>NATHAN KANTER 4002 HIGH POINT RD. 21043</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE) <b>Acute Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Heart Syndrome Ca Heart</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-6-82</b> 19 to <b>3-22-82</b> 19, that (I) (we) last saw the deceased alive on <b>3-22-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>HOWARD GARBER</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-20-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWARD GARBER</b>		22e. ADDRESS <b>5310 OLD COURT RD. (21133)</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>4-20-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HAR SINAI BENEV. SOC.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE, BALD. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 23 1982</b>			
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 7 days after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Wesley RATHMELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1982</b>		2b. HOUR <b>10:45<sup>P</sup></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 15, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rossville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ryder Truck Rental- Purchasing</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward D. Rathmell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Mackey</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>190-03-7982</b>		17. INFORMANT ADDRESS <b>Susan E. Voorhees Lutherville, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1629 Cardio-pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <b>Chronic Obstructive Pulmonary Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 5, 1982</b> , to <b>April 11, 1982</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <b>April 11, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <b>J. FERNANDEZ</b>				22c. DATE SIGNED <b>4/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. FERNANDEZ</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 14, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cem.</b>	
23d. LOCATION CITY OR TOWN <b>Chase Baltimore, Maryland</b>		23e. NAME OF CEMETERY OR CREMATORY <b>Chase Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 12 1982</b>	

1. *[Faint, illegible text]*  
 2. *[Faint, illegible text]*  
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 7. *[Faint, illegible text]*  
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 10. *[Faint, illegible text]*



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 9 9  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGIE MARY RAWLINGS			2a DATE OF DEATH MONTH DAY YEAR April 4, 1982		2b HOUR 9:45 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 8, 1903		
6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN		
9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cumberland, Md.		10 CITIZEN OF WHAT COUNTRY? USA		11 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD		
12 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		14 KIND OF BUSINESS OR INDUSTRY		
15 CITY OR TOWN OF DEATH Reisterstown			16 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3214 Black Rock Road			
17 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a STATE Md.		18b COUNTY Balto.		18c CITY OR TOWN Reisterstown		
19 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19a STREET ADDRESS 3214 Black Rock Road				
20 FATHER'S NAME FIRST MIDDLE LAST John Dellbrook			21 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rella Unknown			
22 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		23 SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-38-5818		24 INFORMANT ADDRESS Mrs. Mary Virginia Brown Reisterstown, Md.		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic obstructive Pulmonary Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years <u>4</u>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d LOCATION STREET CITY OR TOWN COUNTY STATE	
21e INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a I certify that (I) (this hospital) attended the deceased from <u>8-7-1959</u> to <u>4-4-1982</u> , that (I) (we) last saw the deceased alive on <u>4-1-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>C. E. McWilliams MD</u> DEGREE		22c DATE SIGNED <u>4-5-82</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. E. McWilliams</u>		22e ADDRESS <u>11904 Reisterstown Rd. Reisterstown Md. 21136</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE April 7, 82		23c NAME OF CEMETERY OR CREMATORY All Saints Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Reisterstown, Md.		24 FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136			
25a DATE REC'D BY REGISTRAR APR 6 1982		25b REGISTRAR'S SIGNATURE <u>Francis J. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 0 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rose RAY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4 20 1982</b>				2b. HOUR <b>2:05 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 26 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS <b></b>		IF UNDER 24 HRS. HOURS MIN. <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>							
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6522 Woodbridge Circle 21228</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Balzer</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Kroeger</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-01-3001</b>		17. INFORMANT <b>Doris M. Sohl</b>		ADDRESS <b>1454 Grandview Road Arnold, Maryland 21012</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary Artery Disease, Hypertension, Degenerative Arthritis, Diabetes Mellitus</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1132 N. Rolling Rd., Baltimore, Md. 21228</b>									
22a. I certify that (I) (this hospital) attended the deceased from <b>4-15-82</b> to <b>4-20-82</b> , that (I) (we) lost saw the deceased alive on <b>4-15-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>J. Nelson McKay M.D.</b>										DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/20/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
<b>J. Nelson McKay M.D.</b>					<b>1132 N. Rolling Rd., Baltimore, Md. 21228</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/22/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Dorsey MD.</b>							
24. FUNERAL DIRECTOR NAME <b>Witzke P.A.</b> <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 20 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thom...</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 208801	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>Stella C Ray</u>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <u>4 11 1982</u>		2b. HOUR <u>5:28 PM</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>March 15, 1912</u>		6. AGE (IN YEARS) (LAST BIRTHDAY) <u>70</u> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <u>4 11 1982</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Cabins West Virginia</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balti County</u> MD		2d. HOUR <u>5:28 PM</u>	
10. CITY OR TOWN OF DEATH <u>Randallstown</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Balto. Co. Gen. Hospt.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>Md.</u>		13b. COUNTY <u>Balto.</u>		13c. CITY OR TOWN <u>Reisterstown</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>1117 Berryman's Lane</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Alfred Moyers</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Laura Goldizen</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>220-54-9018</u>		17. INFORMANT ADDRESS <u>Mr. Harry B. Ray Reisterstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>2500</u> IMMEDIATE CAUSE (a) <u>ASCTA</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF <u>DIABETES Mellitus</u> (b) <u>DIABETES Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES Mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>William E. Williams</u> M.D.						TITLE (SPECIFY) <u>Physician</u> MEDICAL EXAMINER			DATE SIGNED <u>4/11/82</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>W. E. Williams</u>						ADDRESS <u>5550 Balt. Nat'l Rm</u>					
23a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>				23b. DATE <u>Apr; 14, 82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westminster Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Eline Funeral Home Reisterstown, Md. 21136</u>						25a. DATE REC'D. BY REGISTRAR <u>APR 14 1982</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Nathan</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BERNA		REESE						4-3-82		10 <sup>50</sup> PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		2-7-84		98					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Missouri		U.S.A.				Baltimore Co.				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Towson		Stella Makis Hospice		Hotel Adm.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				BALTO				6131 Marlora Rd.		21239	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John		Miller		Margaret		Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		481-03-6817		Stella Makis Hospice		2500 Dulany Valley				Towson, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 1/10 19 79 to 4/3 19 82, that (I) (we) lost saw the deceased alive on 4/8 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen K. Dyal		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/3/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen K. Dyal		22e. ADDRESS 8501 LaSalle Rd. Towson Md 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		4/5/82		Green Mount		Balto., Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Henry W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212		APR 6 1982							

MEDICAL CERTIFICATION

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Dr. Martin  
H. W. Johnson  
New York City, N. Y.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REINHARDT</b>		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>04 25 82</b>		2b. HOUR <b>1140 AM</b>	
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>04 20 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CO MD</b>			
10. CITY OR TOWN OF DEATH <b>Parkville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Convalescent</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>Glen Arm</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>10732 Harford Rd</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anton Reier</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Weinreich</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-32-5090</b>		17. INFORMANT ADDRESS <b>Fam. L. Records</b>			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Coronary Artery Disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>4-18 1982</b> to <b>4-25 1982</b> , that (I) (we) lost saw the deceased alive on <b>4-23 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Marion C. Kowalewski MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-26-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARION C. Kowalewski</b>		22e. ADDRESS <b>8604 Harford Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE <b>4/29/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CO MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS Funeral Chapel 8800 Harford Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 0 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LYN I. REINICKER			2a. DATE OF DEATH MONTH DAY YEAR April 1, 1982		2b. HOUR 6:45 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holly Hill Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 4224 Loch Raven Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Robert F. Ingram		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brantly Foster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 46 2724	17. INFORMANT ADDRESS Harvey E. Reinicker, Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 7 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Senile Dementia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>1-30</u> , 19 <u>76</u> , to <u>4-1</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>3-29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William P. Benson, Jr. M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George P. Benson, Jr., M.D.		22e. ADDRESS 15 E. Biddle St., Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/3/82	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			25a. DATE REC'D. BY REGISTRAR APR 5 1982		
			25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 8 8 0 5 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>Hildegard Reissmann</b>		2a DATE OF DEATH MONTH DAY YEAR <b>April 20 1982</b>		7b HOUR <b>5:50 a</b> M	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>6 4 09</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	7b CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD	
10 CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi-medical Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physician</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>Md.</b> 13b COUNTY <b>Balto.</b>		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e STREET ADDRESS <b>Univ. Pkwy. &amp; 39th St.</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>		16b SOCIAL SECURITY NO. <b>467-50-4738A</b>		17 INFORMANT ADDRESS <b>Md. Nat'l Bank P.O. Box 995 - Balto.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 1629 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Small Cell Cancer of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain Metastasis of Cancer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1wk</b> <b>10month</b> <b>4month</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Seizure disorder secondary to brain metastasis, Cont</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Sept 19 82</b> to <b>April 20 19 82</b> , that (I) (we) last saw the deceased alive on <b>Apr 19 19 82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
27b SIGNATURE <b>Howard H Bm d</b>		DEGREE <b>MD</b>		27c DATE SIGNED <b>4/20/82</b>	
27d PHYSICIAN'S NAME (TYPE OR PRINT)		27e ADDRESS		27f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b DATE <b>4/20/82</b>		23c NAME OF CEMETERY OR CREMATORY	
24 FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		23d LOCATION CITY OR TOWN COUNTY STATE	
25a DATE REC'D BY REGISTRAR <b>APR 27 1982</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			

2010 28

*[Faint, mostly illegible handwriting on lined paper]*

*[Faint handwriting at the bottom of the page, possibly a signature or date]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08806

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH			2c. DATE OF DEATH			2d. HOUR		
GLEASON			RICE			April 30, 82			April 30, 82			2		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR					
MALE	WHITE	04 22 10	73 YRS.	MONTHS	DAYS	April 30, 82			2					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA			U. S. A.						BALTIMORE COUNTY			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE			ST JOSEPH HOSPITAL			LITHOGRAPH								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MO.			BALTO.			PARKVILLE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7820 OAKLEIGH ROAD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
JESSIE			FLORENCE			NO			219 012518			FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Generalized ASCVD (c) 5+yr									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			21d. INJURY OCCURRED			21e. PLACE OF INJURY		
			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			CITY OR TOWN		
			P.M. 19									COUNTY		
												STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
EXAMINER'S NAME			ADDRESS											
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. BY REG. NO.		
BURIAL			MAY 4, 1982			MORELAND MEM. PARK			PARKVILLE			BALTO. MD.		
24. FUNERAL DIRECTOR			25a. NAME			25b. ADDRESS			25c. REGISTRAR'S SIGNATURE					
EVANS FUNERAL CHAPL			8300 HARFORD R.						MAY 5 1982					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at a

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 0 7 REG. NO.					
1. FOR STATE REGISTRAR 24															
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Sutton Ridenour										2a. DATE OF DEATH MONTH DAY YEAR 4 21 82				2b. HOUR 7:35 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 03 06		6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.									
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Broadmead				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY City Schools							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13801 York Road							
14. FATHER'S NAME FIRST MIDDLE LAST James R. Sutton				15. MOTHER'S MAIDEN NAME MIDDLE LAST E. Stottlemeyer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-12-2307		17. INFORMANT Richard S. Ridenour		ADDRESS 4 Dodworth Ct. Timonium, Md. 21093									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEFT CEREBROVASCULAR ACCIDENT</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Walter N. Hepner II				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/22/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Hepner, M.D.				22e. ADDRESS 3313 Papermill Rd. Phoenix, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/26/82		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Church		23d. LOCATION CITY OR TOWN COUNTY STATE Hancock, Washington Co., Md.									
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR APR 23 1982									
						25b. REGISTRAR'S SIGNATURE Frances Jean Warren									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN RANDOLPH RIDGLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 8, 1982</b>		2b. HOUR <b>10:45<sup>a</sup> AM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 13 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
10 CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fuel &amp; Meter Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Ridgley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Known</b>		13e. STREET ADDRESS <b>523 Bayside Drive</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-07-6995</b>		17. INFORMANT <b>Virginia Kirts</b> ADDRESS <b>523 Bayside Drive</b> <b>Balto. MD 21222</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest; Pneumococcal</b> <b>2762</b> DUE TO, OR AS A CONSEQUENCE OF <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Metabolic Acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Renal Failure</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) this (hospital) attended the deceased from <b>March 30</b> , 19 <b>82</b> , to <b>April 8</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>April 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not) view the body after death.						
22b. SIGNATURE <b>J. Fernandez</b> DEGREE				22c. DATE SIGNED <b>4 8 82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. FERNANDEZ</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk, Baltimore, Maryland</b>
24 FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, Md 21222</b>				25a. DATE RECD BY REGISTRAR <b>APR 13 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>		

1952-1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 08809

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Dorthy M. Robinson		4 21 82		5:05 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		1 15 01		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cockeysville		Broadmead 13801 York Road		Homemaker		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
William Medders		Olivia Harper Medders		No		214-48-5122	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Joan R. Holman, New Bloomfield, Pa. 17068		CEREBROVASCULAR ACCIDENT					
		DUE TO, OR AS A CONSEQUENCE OF (b) BATTLE DIABETES MELLITIS					
		DUE TO, OR AS A CONSEQUENCE OF (c)					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR	
						P.M. 19	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/21 19 80, to 4/21 19 82, that (we) lost		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
saw the deceased alive on 4/21 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		Walter A. Hepner II M.D.		4/22/82		Dr. Walter A. Hepner, M.D.	
22e. ADDRESS		22f. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Boradmead, Cockeysville, Maryland				Cremation		4/23/82	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Green Mount		Balto., Md.		APR 26 1982		James J. VanNathan	
24. FUNERAL DIRECTOR NAME		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION	
Henry W. Jenkins & Sons Co.		4/23/82		Green Mount		Balto., Md.	
4905 York Road Balto., Md. 21212							

BP

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From: Mr. J. H. ...

For: ...

New York, N.Y.

John F. ...

No.

...



...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 1 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSHUA RUF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>WED. APRIL 28, 1982</b>		2b. HOUR MIN. <b>12:13PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 10, 1915</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMPLOYED</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>GROCER</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5 WILD CHERRY CT. (21207)</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>MENDEL RUF</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA WEINER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-30-7340</b>	17. INFORMANT ADDRESS <b>MRS. BETTY RUF 5 WILD CHERRY CT. (21207)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>VENTRICULAR FIBRILLATION</b> (c) <b>ACUTE MYOCARDIAL INFARCTION</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>OLD INFERIOR MYOCARDIAL INFARCTION; ASHD.</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 23, 1981</b> to <b>APRIL 28, 1982</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 22, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bernard Rubin</b>	DEGREE <b>PHYSICIAN</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>4-29-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD RUBIN (M.D.)</b>		22e. ADDRESS <b>3502 CROYDON ROAD BALTIMORE, MD. 21207</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>4-29-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MENS CEM</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN, MD. BALTO. MD</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 4 1982</b>			
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

01383

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE  
OF THE  
SECRETARY

WASHINGTON  
D. C.  
20250



UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical team must be notified to report.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR		8 2 0 8 8 1 1 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LOUIS		J		SAGNER		APRIL 17, 1982		4:22PM		M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		AUG. 29, 1900		81		MONTHS DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
RANDALLSTOWN		BALTIMORE COUNTY GEN HOSP						ATTORNEY		LAW	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS (21208)			
MARYLAND		BALTIMORE		PIKESVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7311 PARK HEIGHTS AVE. APT. 207			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
ABRAHAM				JENNIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF UNKNOWN))				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS (21208)					
NO				217-20-3423		MRS. GLORIA HARRIS 7925 LONG MEADOW RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Presumed Cardiorespiratory arrest										Terminal	
4100											
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD - S/P MI & Cardiac arrhythmia										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
Samuel E. Benosh MD								MD		4-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
Samuel E. Benosh, MD								11 Slade Ave Balt MD 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				4-19-82		BETH TFILOH CONG. CEM		BALTO WOODLAWN, MD. BALTO MD			
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR	
SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)								APR 21 1982		James J. Hinkle	

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RECEIVED

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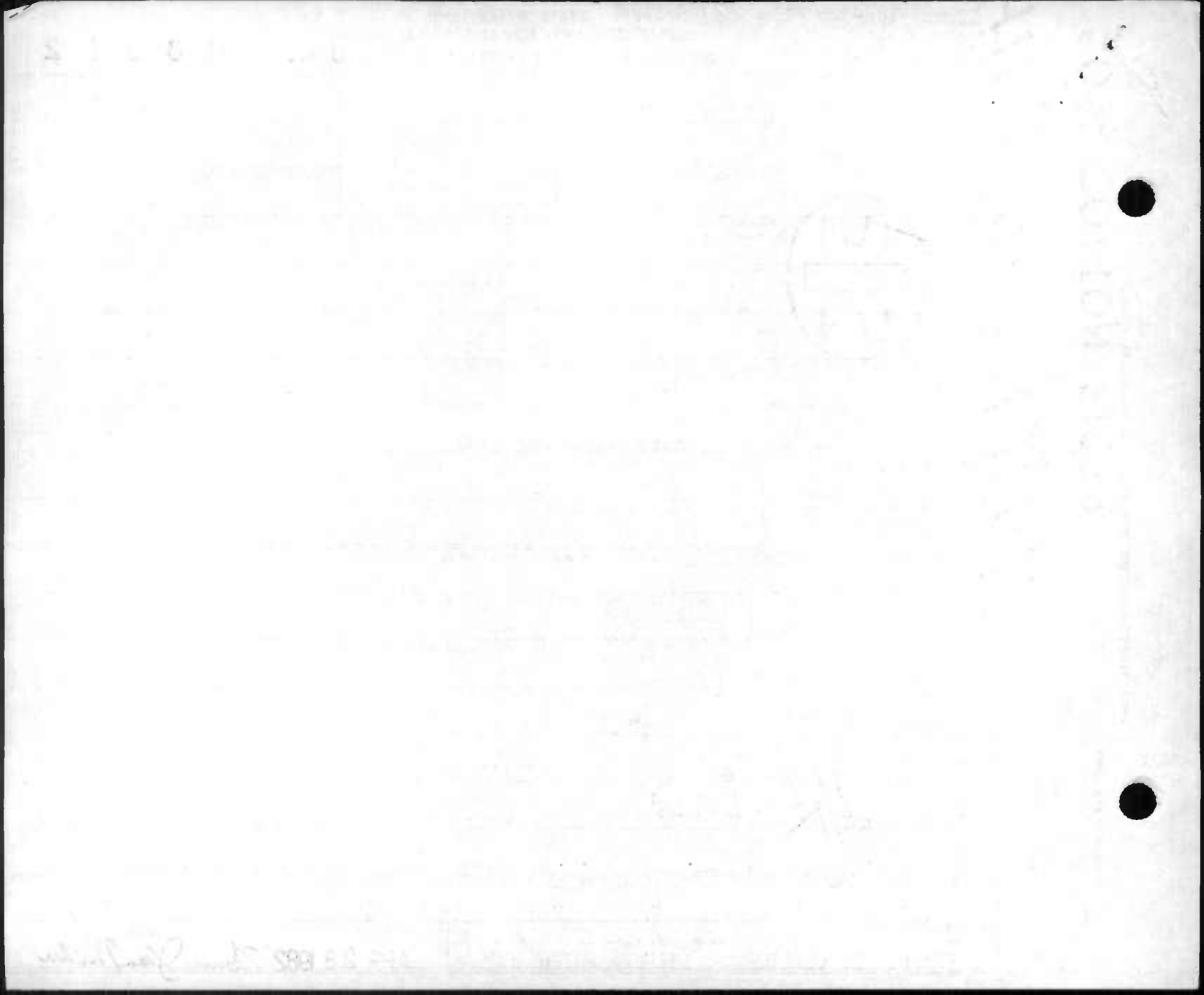
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APR 1 1955

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08812			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary EVELYN LUALLEN Sales										2a. DATE KNOWN OF DEATH ESTIMATED X 4 19 1982		2b. HOUR M 11:45	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR JUNE 12 41 40 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 4 20 1982		7d. HOUR 11:45			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Essex				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1603 Gail Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1427 KANAHAWA ST.			
14. FATHER'S NAME FIRST MIDDLE LAST HARDIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN M. SHORT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-42-6559		17. INFORMANT LILLIAN M. WILLIS		ADDRESS 6304 TULSA LA. BETHESDA, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Acute Lobar Pneumonia</u> 4810 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE H. R. Guard				TITLE (SPECIFY) Assistant				DATE SIGNED 4/21/82					
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto, MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 4-28-82		23c. NAME OF CEMETERY OR CREMATORY MT. COMMON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CORINTH ALCORN MISS.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				24b. ADDRESS 5000 UNIVERSITY BLVD. WEST SILVER SPRING, MD		24c. DATE REC'D. BY REGISTRAR APR 28 1982		25b. REGISTRAR'S SIGNATURE James Van Natten					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 8 1 3 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
FIRST MIDDLE LAST SCHAPIRO MAX B.				2a. DATE OF DEATH MONTH DAY YEAR 4- 4-5-82			
2b. HOUR 2-30A M							
3 SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 27 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO. MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE WORK OR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD. BALTO. REISTERSTOWN		13b. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 314 HOLLY HILL RD.			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST POLA FIXEL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-106401A	
17. INFORMANT ADDRESS MARTERIE F. SCHAPIRO SAME. 21136							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest 4-100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 20 to acute MI attack with (c) Cardiogenic shock.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-22-1982, to 4-5-1982, that (I) (we) lost saw the deceased alive on 4-5-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.M. Shah, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-5-82.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH.				22e. ADDRESS B.C.G.H. OLD COURT RD & 116th RD. RANDALLSTOWN.			
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 4-6-82		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM.		23d. LOCATION CITY OR TOWN COUNTY BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS NEWELL F.H. 1100 REISTERSTOWN RD.				25a. DATE REC'D. BY REGISTRAR APR 8 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

19

0000 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 1 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIE ROSINA SCHARPF</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>4 13 82</b>				2b. HOUR M <b></b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 18</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>64 63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b></b>		IF UNDER 24 HRS. HOURS MIN. <b></b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE County MD</b>								
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>600 S. Light St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk Teacher.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Credit Service</b>						
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>600 S. Light St.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>William George Scharpf</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lang</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-22-6353</b>		17. INFORMANT <b>Louise Restivo</b>				ADDRESS <b>Vero Beach, FL</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute MI</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COLD</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b> <b>low</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Schizophranic</b>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT (IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>6-18</b> , 19 <b>82</b> , to <b>3-18</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>4-10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Alejandro Mejia</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4-15-82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALEJANDRO MEJIA, M.D.</b>				22e. ADDRESS <b>1900 SULPHUR SPRING RD #51227</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-16-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>							
24. Funeral Home NAME ADDRESS <b>G. Truman Schwab, P.A. 3512 Frederick Ave. #21229</b>				25a. DATE REC'D BY REGISTRAR <b>APR 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

4 1 8 8 0 5 8

Figure 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 2 0 8 8 1 5

FOR  
1- REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPHINE</b>		FIRST		MIDDLE		LAST <b>SCHAUB</b>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>4 2 1982</b>		7b. HOUR M	
3 SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar 2, 1910</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>72</b>		IF UNDER 1 YR MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 6 1982</b>		2d. HOUR M <b>1030</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		MD			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2900 Dunbrin Rd Apt A</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2900 Dunbrin Rd Apt A</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Dombrowski</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Veronica Gutowski</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-01-0295</b>		17. INFORMANT <b>Daniel Dombrowski</b>		ADDRESS <b>11717 Hillside Rd Kingsville, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b> 4310 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Chronic emphysema</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J. C. Crossan O'Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>4/6/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>				ADDRESS <b>2112 DUNDALK AVE, BALT., MD. 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Stanislaus</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 8 1982</b> REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					

2100 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 8 1 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY Grayson SCHIFFERER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 15 '82</b>		2b. HOUR <b>11:50P</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 28 '10</b>	6. AGE (IN YEARS (LAST BIRTHDAY)) <b>71</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>1306 Appleby Ave 21209</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christian Schifferer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Janie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-07-1559A</b>	17. INFORMANT ADDRESS <b>Robert V Worthington 58 Belfast Rd 21093</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>VENTRICULAR TACHYCARDIA</b> 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL ISCHEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>4-15</b> 19 <b>82</b> , to <b>4-15</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4-15</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Ricely</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>4/10/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES RICELY, M.D.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4-19-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 19 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Schimming</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 26 82</b>			2b. HOUR <b>7:05</b> A M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 23 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Tawes Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Brakeman Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Jarrettsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ferdinand Schimming</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>N/A</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WWI Army</b>		17. INFORMANT (Son) ADDRESS <b>Francis Schimming, Same as # 13.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>20 yrs.</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/19/80</b> to <b>4/26/82</b> , that (I) (we) lost saw the deceased alive on <b>4/26/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Emma M. Woody MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>4/26/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Emma M. Woody MD</b>						22e. ADDRESS <b>SPRING GROVE STATE HOSP. CATONSVILLE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jones Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Amity Clark Ark.</b>		
24. FUNERAL DIRECTOR NAME <b>E. Barnes</b> ADDRESS <b>Fleming Funeral Service Benson, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 1 8  
REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna K. Schmenner			2a. DATE OF DEATH MONTH DAY YEAR April 8, 1982		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 22, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Dewitt C. Kemp			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Brunner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-1308 D		17. INFORMANT ADDRESS 3 Chapel Ct. Charles H. Schmenner, Jr. Timonium, Md. 21093	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Respiratory Failure (3 days) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized ASCVD (+/- 3 yrs) (c) DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/1 1979 to April 8, 1982, that (I) (we) last saw the deceased alive on April 7, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles F. O'Donnell				22c. DATE SIGNED 4/9/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. O'Donnell				22e. ADDRESS 7501 York Road Towson, Md 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-12-82		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS 1050 York Rd. Baltimore, Md. 21204				25a. DATE REC'D. BY REGISTRAR APR 12 1982	
				25b. REGISTRAR'S SIGNATURE [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08819	
1. DECEASED NAME (TYPE OR PRINT) * <b>LARRY JOSEPH SCHNEIDER</b>												2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4</b> DAY <b>12</b> YEAR <b>1982</b>	2b. HOUR <b>1500</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>22</b> YEAR <b>57</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>24</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>12</b> YEAR <b>1982</b>	7d. HOUR <b>2130</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6723 Railway Avenue</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>loborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Canton El. Co</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6723 Railway Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>loborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Canton El. Co</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6723 Railway Avenue</b>					
14. FATHER'S NAME FIRST <b>Norman</b> MIDDLE LAST <b>Schneider</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b> MIDDLE LAST <b>Chorlog</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Norman Schneider 7954 Eastdale Rd</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self-inflicted gunshot wound of chest</b> 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>1500</b> A.M. MONTH <b>4</b> DAY <b>12</b> YEAR <b>1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted gunshot</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>6723 Railway Ave.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>21222</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>4/12/82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>				ADDRESS <b>2112 Dundalk Ave., Balb., Md. 21222</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>4/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md</b> STATE <b>Md</b>				
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b> ADDRESS <b>1005 Dundalk Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 15 1982</b>				25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>					

Waller Brothers

1005 Dundalk Avenue

Cremation

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Green Point

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Schneider

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Norman Schneider 1934 Eastdale Rd

Baltimore

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Robert

Canon St. Co

white

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USA

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Baltimore County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 2 0					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Hazel C. Schnepf										2a. DATE OF DEATH MONTH DAY YEAR 4 12 82				2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 28 1916			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7909 St. Clair Lane					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7909 St. Clair Lane							
14. FATHER'S NAME FIRST MIDDLE LAST George Parlett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Coldwell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-03-1994		17. INFORMANT 7909 St. Clair Lane John H. Schnepf Balto., MD. 21222											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>4960</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>SEVERE CHRONIC OBSTRUCTIVE/RESTRICTIVE LUNG DISEASE MORE THAN 5 YRS</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ DUE TO, OR AS A CONSEQUENCE OF _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Previous C.V.A. &amp; @ Dam weakness; Premature ventricular contractions</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>4/5 82</u> to <u>4/12 82</u> , that (1) (we) last saw the deceased alive on <u>4/5 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>James M. Pargament, M.D.</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/12/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. PARGAMENT				22e. ADDRESS 9578-13 Phila. Rd. Balt. Md 21237											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/15/1982		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD							
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR APR 14 1982									

08300/28

APR 14 1985  
JAN 14 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or another traumatic event, the medical examiner must be notified by item 18.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 2 1 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM A SR SCHOEBERLEIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>04 20 82</b>		2b. HOUR M <b>AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 6, 1897</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS HOURS MIN <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.M. Auto</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5407 Bucknell Road</b>		21206	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John G. Schoeberlein</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Frederick</b>				ADDRESS <b>21206</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-01-5079</b>		17. INFORMANT <b>John G. Schoeberlein</b>				ADDRESS <b>5407 Bucknell Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Myocardial Infarction</i> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert H. D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/20/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr 23 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Baltimore Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 22 1982</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>Baltimore, Maryland</b>				25. DATE REC'D. BY REGISTRAR <b>APR 22 1982</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to testify.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 2 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARION		MIDDLE D.		LAST SCHREIBER		2a. DATE OF DEATH MONTH DAY YEAR April 3, 1982		2b. HOUR 8:00A	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 5, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD					
10 CITY OR TOWN OF DEATH 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8323 Oakleigh Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8323 Oakleigh Road			
14 FATHER'S NAME FIRST MIDDLE LAST George Dunn		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Henry W. Schreiber Balto., MD 21234							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC CONGESTIVE HEART FAILURE</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.											
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/5/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RIVERA		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 6, '82		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD					
24 FUNERAL DIRECTOR NAME William E. Johnson		ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRS 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 8 2 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Margaret Cecelia Schuman MARGARET Cecelia Schuman				2a. DATE OF DEATH 4/5/82		2b. HOUR 7:01 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10 24 07		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley Nursing Conv. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Sewing Factory	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Essex	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Hall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Whitworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 213 05 3338		17. INFORMANT ADDRESS Donna Schenning (Daughter) Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 6 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/1/82 to 4/5/82, that (I) (we) lost saw the deceased alive on 4/1/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. MacDonnell				DEGREE MD		22c. DATE SIGNED 4/6/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. MacDonnell				22e. ADDRESS 9 S. Highland Ave 21224			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE April 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home				25a. DATE REC'D. BY REGISTRAR APR 6 1982			

MEDICAL CERTIFICATION

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NAME	ADDRESS	CITY	STATE	ZIP
Mr. J. B. Smith	123 Main St.	Springfield	Ill.	62761
Mr. J. B. Smith	123 Main St.	Springfield	Ill.	62761
Mr. J. B. Smith	123 Main St.	Springfield	Ill.	62761
Mr. J. B. Smith	123 Main St.	Springfield	Ill.	62761
Mr. J. B. Smith	123 Main St.	Springfield	Ill.	62761
Mr. J. B. Smith	123 Main St.	Springfield	Ill.	62761
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16-30M 2/80  
(VRA 15, 4)

Item 16b g567 5/18/82 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LARNER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4 25 82</b>		2b. HOUR <b>11:35 PM</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 13 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>		10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>GBMC-6701 N. CHARLES ST.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.-Freight Conductor</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cockeysville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Seaman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Larner</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
17. SOCIAL SECURITY NO. <b>WW11</b>		18. INFORMANT <b>Mrs. Katherine Seaman</b>		19. ADDRESS <b>21030 10302 E. Malcolm Cr. Cockeysville, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>CARDIOPULMONARY ARREST</b> IMMEDIATE CAUSE (a) <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF <b>LUNG CANCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DISSEMINATED INTRAVASCULAR COAGULATION</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 24 82</b> , 19 <b>82</b> , to <b>APRIL 25 82</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive or above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Elisa Brown Soltero</b>	
22c. DATE SIGNED <b>4/26/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELISA BROWN SOLTERO, MD.</b>		22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vet. Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Anne Arundel MD.</b>		24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 27 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>		25c. ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>			

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 0 8 8 2 5			
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN GEORGE SEDAR</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4/20 1982</b>		2b. HOUR <b>7:00 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 9 1903</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>79 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3419 Yorkway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Service</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3419 Yorkway</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Sydor</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Gurnock</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Gertrude D. Sedar</b>				ADDRESS <b>3419 Yorkway Balto., MD. 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic cardiovascular atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										-APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>① Diabetic Mellitus</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>K. S. Ahluwalia</b>				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>4/20/82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>K. S. AHLUWALIA</b>				ADDRESS <b>2112 Dundalk Ave Balt 21222</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/23/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 23 1982</b> REGISTRAR <b>Frances J. [Signature]</b>							
7922 Wise Avenue Dundalk, MD. 21222													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 18.DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 2 6			
1 - FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY M. SEEFELD</b>										2a. DATE OF DEATH MONTH <b>4</b> DAY <b>1</b> YEAR <b>1982</b>		2b. HOUR <b>8:00 P.M.</b>	
3. SEX <b>F</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>31</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72 yrs</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hos.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5607 Olde Oak Drive</b>					
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Schlisleder</b> LAST <b>Schlisleder</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Frida</b> MIDDLE <b>Broxmeyer</b> LAST <b>Broxmeyer</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>392-03-5925</b>		17. INFORMANT <b>Mary Ann Waskiewicz</b>		ADDRESS <b>Item 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident.</b> <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral thrombosis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic organic Brain Syndrome.</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/24/1982</b> to <b>4/1/1982</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/1/1982</b> , and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I <del>we</del> did) <b>(not)</b> view the body after death.													
22b. SIGNATURE <b>B. K. SINHA</b>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/1/82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. K. SINHA</b>					22e. ADDRESS <b>Baltimore County General Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/6/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Milwaukee</b> COUNTY <b>Wisconsin</b> STATE							
24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, P.A., Damascus, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 7 1982</b>								
					REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>								

MEDICAL CERTIFICATION

C S E S G

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 8 2 7  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SHIRLEY SEIDMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 8, 1982</b>		2b. HOUR P. M. <b>6:30 P.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR. 3, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>56</b>	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9500 ALLENSWOOD RD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERVISOR</b>		12b. KIND OF DISEASE OR INJURY <b>LEUKEMIA SOC. OF MD</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>RANDALLSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISRAEL NEEDEL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EVA ADLER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-24-7420</b>	
17. INFORMANT <b>LOUIS SEIDMAN ALVAN NEEDEL</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension and liver failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Undifferentiated carcinoma of gall bladder and liver metastatic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Taundice</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1982 February 19, 82</b> to <b>April 3, 1982</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M. Didolkkar</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. DIDOLKKAR, M.D.</b>		22e. ADDRESS <b>UNIV. HOSP. = BALTO., MD</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 11, 1982</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FORBAND</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>		24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 15 1982</b>	
24. FUNERAL DIRECTOR ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>		25c. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 8 8 2 8			
1. FOR STATE REGISTRAR										2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen V. Seim										MONTH DAY YEAR 4 9 1982			
3. SEX Female										2b. HOUR 8:30 PM			
4. RACE White										5. DATE OF BIRTH MONTH DAY YEAR May 13, 1905			
6. AGE (IN YEARS LAST BIRTHDAY) 76										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.										7b. CITIZEN OF WHAT COUNTRY? USA			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Lutherville Timonium										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1813 Blakefield Circle			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Lutherville Timonium										12b. KIND OF BUSINESS OR INDUSTRY			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS 1813 Blakefield Circle			
14. FATHER'S NAME FIRST MIDDLE LAST George A. Bratt										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Gettier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no										16b. SOCIAL SECURITY NO. 216 46 2920			
17. INFORMANT ADDRESS Sewell A. Brown Jr Same													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast metastases</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/8/67			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4/9/82													
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE _____ DEGREE _____										22c. DATE SIGNED 4/12/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.M. Duggan M.D. P.A.										22e. ADDRESS 15 E. Biddle St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 4/13/82			
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cent.										23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto Md			
24. FUNERAL DIRECTOR NAME Mitchell- Wiedefeld Home										25a. DATE REC'D. BY REGISTRAR APR 14 1982			
25b. REGISTRAR'S SIGNATURE Anne J. [Signature]													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 2 9							
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
James		M		SEXTON		April 27, 1982		7:00am									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
M		W		9/11/20		61		YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
KY		USA				Baltimore County										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
ROSSVILLE		FRANKLIN SQ.		RETIRED													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
MD.		BALTO		ESSEX				1016 MIDDLESEX									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
ISSAC		FLORENCE		SEXTON		WILLIAMS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
UNK		40312 4335		EDELTRAU		SEXTON		ABOVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Respiratory Arrest, Resistant Congestive																	
4280																	
DUE TO, OR AS A CONSEQUENCE OF										Heart Failure							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 8, 19 82, to April 27, 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 27, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did (did not) see the body after death.																	
22b. SIGNATURE						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED							
Michael Gosney						MD				4/27/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS											
Michael Gosney, M.D.						9000 Franklin Square Dr. Balto., MD 21237											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		4/29/82		HOLY HILL		BALTO.		MD.									
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
J.G. CONNELLY						300 MACE						APR 28 1982		Thomas J. Connelly			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 8 3 0  
REG. NO.

1 - FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Olive H. Shackelford		2a. DATE OF DEATH MONTH DAY YEAR 4-17-82		2b. HOUR 11 45 P M	
3 SEX male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 7 24 91		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD	
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bent Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Food Broker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md		13b. COUNTY Balto		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST late James B. Shackelford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Cornelia Ambrose		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
16b. SOCIAL SECURITY NO. 215-10-2964		17 INFORMANT ADDRESS Mr. O. Hinton Shackelford Jr 405 Old Orchard					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic CV Disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-15-1975 to 4-17-1982, that (I) (we) last saw the deceased alive on 4-16-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C.E. McWilliams M.D.				DEGREE M.D.		22c. DATE SIGNED 4-17-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) O.E. McWilliams M.D.				22e. ADDRESS 11904 Reisterstown Rd Reisterstown MD 21136			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE April 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Harry H Witzke				25a. DATE REC'D. BY REGISTRAR APR 20 1982			
ADDRESS 4112 Columbia Road Ellicott City				REGISTRAR James J. Hinton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
JAN 20 1910  
OFFICE OF THE CHIEF OF BUREAU  
PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 3 1	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>EMA SHEAR</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>4-3-82</b>				2b. HOUR <b>5:12 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 20, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. TYPE OF BUSINESS OR INDUSTRY <b>MOTOR VEHICLES</b>			
13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>3317 NORTHMONT RD. #21207</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM SHEAR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RACHAEL GOLDSMITH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-09-1838</b>		17. INFORMANT <b>MR. HARRY SHEAR</b> <b>4001 CLARKS LA., APT. 407</b>				#21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis of return</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Heart disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>1/11/82</b> to <b>4/3</b> 19 <b>82</b> that (2) (we) last saw the deceased alive on <b>4. 2. 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Narayan</b>						DEGREE			22c. DATE SIGNED <b>4/3/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. NARAYEN</b>						22e. ADDRESS <b>BALTIMORE COUNTY GEN. HOSP OLD CT. RD, BALTIMORE, MD 21207</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>APR. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ADATH YESHURUN (SODOVA)</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>						ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25. REC'D. BY REGISTRAR <b>APR 8 1982</b>		

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EMA 2-2-3 2-2-3

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be retained by the hospital or attending physician.

TO BE DETACHED FOR USE AS THE BURIAL TRANSIT PERMIT. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 3 2					
1- FOR STATE REGISTRAR					REG. NO.										
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					2b HOUR					
SYLVIA MARION SHIFREN					04 30 82					3 10 A M					
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR			IF UNDER 24 HRS.		
FEMALE		CAUCASION		11 11 15			66 YRS.			MONTHS			DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA						BALTIMORE COUNTY MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
RANDALLSTOWN		BALTIMORE COUNTY GEN. HOSP.								BOOKKEEPER			ACCOUNTING		
13a STATE					13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS				
MARYLAND					BALTO.		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		APT. 102 7918 DUNHILL VILLAGE CIR. 21207				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME										
MORRIS					GOLDBERG					BESSIE UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT			17b ADDRESS					
NO					214-12-4115		IRVIN SHIFREN			7918 DUNHILL VILLAGE CIR., APT. 102 #21207					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION WITH 4100															
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROTIC HEART DISEASE															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d INJURY OCCURRED				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 03-21-1982 to 04-30-1982, that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE				DEGREE				22c DATE SIGNED							
DR. BUDHIR PATEL								04-30-82							
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS											
DR. BUDHIR PATEL				BAL. COUNTY GEN. HOSPITAL											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION					
BURIAL				MAY 2, 1982		TIFERETH ISRAEL ANSHE SEARD				ROSEDALE BALTO. MD					
24 FUNERAL DIRECTOR				25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
SOL LEVINSON & BROS., INC.				MAY 4 1982				James J. Nathan							
6010 REISTERSTOWN RD. BALTO., MD 21215															

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 3 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HARVEY Clifton SHIPLEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>04 11 82</b>				2b. HOUR <b>9<sup>40</sup> AM</b>				
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 27 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Presser=House of</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Worster Tex</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rockdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3613 Hilmar Road 21207</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Clinton Shipley</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Golda Pearl Hamilton</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT <b>Mrs. Viola R. Shipley</b>		ADDRESS <b>3613 Hilmar Road Baltimore, MD. 21207</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SMALL CELL CANCER LUNG</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO OR AS A CONSEQUENCE OF WITH METASTASIS</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.													
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) <b>---</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>---</b>		CITY OR TOWN <b>---</b>		COUNTY <b>---</b>		STATE <b>---</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-11-1982</b> to <b>4-11-1982</b> , that (I) (we) lost saw the deceased alive on <b>4-11-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Sudhir Patel</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>4-11-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SUDHIR. PATEL</b>					22e. ADDRESS <b>Bal. County Gen. Hosp.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-14-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster, Carroll MD</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>						

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1981 13 1982  
James Earl Ray

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 3 4

REG. NO.

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Mary	MIDDLE Jane	LAST SIGMON	2a. DATE OF DEATH April 26, 1982	MONTH DAY YEAR	2b. HOUR 10:18am
3. SEX F	4. RACE W	5. DATE OF BIRTH 10/18/32		6. AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			MD.		
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN MIDDLE RIVER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7355 CHESAPEAKE RD				
14. FATHER'S NAME FIRST ROBERT		MIDDLE L.	LAST M. MULLEN	15. MOTHER'S MAIDEN NAME FIRST FANNIE		MIDDLE M.	LAST CLARK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 30 1516		17. INFORMANT THURMAN SIGMON		ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular disease</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>with Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 25</u> , 19 <u>82</u> , to <u>April 26</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 26</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE P.A. Baltatzis MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/26/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Panayotis Baltatzis, M.D.				22e. ADDRESS 9000 Franklin Square Dr. Balto. MD 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/29/82		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR APR 28 1982		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	7b. HOUR	
SADIE		R	SILL		MAR 1 1982					11:02	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female	White	4 1 1984		97		MONTHS		DAYS		HOURS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		9c. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.		Baltimore County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		Dulaney-Towson Nursing Home				Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland							Baltimore		1558 Wadsworth Way		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST					FIRST MIDDLE LAST						
Clinton Norris					Virginia Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
No					213-74-6062		Mrs Elizabeth Schellhase Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS AID - LVA - CNF 2500 DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL THROMBOSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): BLINDNESS - CATARACTS + MACULAR DEGENERATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/17/82 to 2/18/82, that (I) (we) last saw the deceased alive on 2/17/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DONALD W. MINZER MD.				22c. DEGREE MD.				22d. DATE SIGNED 2/1/82			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS							
DONALD W. MINZER MD.				3009 EVERGREEN AVE BALTO MD 21214							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		3/4/82		Loudon Park		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME				24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR			
Leonard J Ruck Inc. Baltimore, Maryland								MAR 2 1982			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 3 6

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
FIRST MARY		4 8 82		4 30 P.M.	
MIDDLE		LAST SILVERMAN			
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		WHITE		MONTH DAY YEAR	
				MARCH 26, 1909	
6. AGE (IN YEARS LAST BIRTHDAY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
73		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
BALTIMORE COUNTY		RANDALLSTOWN		(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
BALTIMORE CITY		BALTIMORE COUNTY GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
				SECRETARY	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
A. SCHRETER & SON		MARYLAND		BALTIMORE	
		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
HARRIS		KAMNKOW		(YES, NO OR UNKNOWN)	
				(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
213-01-8494		MR. HERBERT SILVERMAN		PART I. DEATH WAS CAUSED BY	
2904 TERRY DR., APT. D		#21209		IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Lung (primary?) (metastatic breast?)</u>	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b) <u>St. post. Left radical mastectomy</u>	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c) <u>Progressive deterioration - Intestinal obstruction</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
<u>Intestinal obstruction diffuse acutal carcinoma</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
4.382		Intestinal obstruction (colonic)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
AT WORK AT WORK					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Yehuda G. Adam				4.8.82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Y. G. ADAM				BALTO COUNTY GEN. HOSP.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		APR. 11, 1982		BETH YEHUDA ANSHE KURLAND	
				BALTIMORE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME SOL LEVINSON & BROS., INC.		APR 15 1982		James J. Nathan	
ADDRESS					
6010 REISTERSTOWN RD. BALTO., MD 21215					

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100 15 200 30 300 45 400 60 500 75 600 90 700 105 800 120 900 135 1000 150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 3 7 REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louisa Elizabeth Sims</i>						2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>April 1 1982 9:11 AM</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 14 1939</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>83</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>					
10. CITY OR TOWN OF DEATH <i>White Marsh</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>24237 10560 Philadelphia Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaking</i>			
13a. STATE <i>Maryland</i>						13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>White Marsh</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Smith</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Matilda Nicols</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>4292</i>		17. INFORMANT ADDRESS <i>Evelyn R. Craze 10556 Philadelphia Rd</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic CVD</i> (c) <i>Arteriosclerotic CVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic CVD</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>1982</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>3-25-82</i> to <i>March 1982</i> , that (I) (we) lost <i>3-25-82</i> above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William A. Tyson</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4-1-82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm. A. Tyson</i>				22e. ADDRESS <i>Box 158 Kingsville MD. 21087</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/5/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Zion Ch. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Golden Ring Baltimore Md</i>					
24. FUNERAL DIRECTOR NAME <i>Lassahn Funeral Home</i>				ADDRESS <i>7401 Belair Road</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 6 1982</i> 25b. REGISTRAR'S SIGNATURE <i>James G. [Signature]</i>			

MEDICAL CERTIFICATION

10000 18

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 3 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Donis M Skolinski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-30-82</b>		2b. HOUR <b>3:50 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 9 1926</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>55</b> YRS		
10 CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Rossville</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CO MD</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>				
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH PLUM</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>39-10-4688</b>		17. INFORMANT NAME ADDRESS <b>MARYANN SKAGGS 544 BURLINGTON ST</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Cardiorespiratory arrest**  
4960  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Respiratory failure**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **COPD & decreased pulmonary reserve**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
**Known recurrence of lung cancer**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/21</b> 19 <b>81</b> to <b>4/30</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>4/28</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>N. Haroun</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NAJJI HAROUN</b>				22e. ADDRESS <b>9101 Franklin Square Dr., Balto. 21237</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5-3-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST STANISLAVS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC</b>				25a. DATE RECD. BY REGISTRAR <b>MAY 4 1982</b>			

100% COTTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 3 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SILMAR, ALEXIS, SKLAREVSKI				2a. DATE OF DEATH MONTH DAY YEAR 4-16-82				2b. HOUR 1356	
3 SEX Male		4 RACE White		5 DATE OF BIRTH July 21, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 72		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY, MD.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Alexander Sklarevski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louise Ludger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-2375		17 INFORMANT ADDRESS Mrs. Mary Sue Sklarevski 34 Wilfred Court					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (b) (we) lost saw the deceased (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)									
22b. SIGNATURE Richard Biggs		22c. DATE SIGNED 4-16-82				22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS 1050 York Road Towson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-19-1982		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION Pikesville COUNTY Maryland			
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		25a. DATE RECEIVED BY REGISTRAR APR 19 1982		25b. SIGNATURE Frances Jan Thorton					

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*[Faint, mostly illegible text covering the majority of the page, appearing to be a list or ledger with multiple columns.]*

APR 19 1982  
JAN 19 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MOLLIE M SMELTZER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-1-82</b>		2b. HOUR M <b>2:00am</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 24, 1896</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>86</b>		
10 CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN USE FOR GRAVE OR CREMATION) <b>ST. JOSEPH HOSPITAL</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Monkton</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles W. Myers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Kessler</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-48-0331</b>		17. INFORMANT ADDRESS <b>16941 York Road Glenn E. Smeltzer, Monkton, Md. 21111</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1, or Part 2)				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (this hospital) attended the deceased from <b>3-26</b> 19 <b>82</b> to <b>4-1</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>4-1</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.						
22a. SIGNATURE <b>Arnold Hanson</b>		DEGREE <b>Physician</b>		22c. DATE SIGNED <b>4-1-82</b>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arnold Hanson</b>		22d. ADDRESS <b>7620 YORK ROAD TOWSON MD 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (EXCEPT) <b>Burial</b>		23b. DATE <b>4-5-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shrewsbury Lutheran</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Shrewsbury, York, Penna.</b>		23e. NAME OF FUNERAL DIRECTOR <b>J. J. Hartenstein</b>		23f. ADDRESS <b>New Freedom, Pa.</b>		
23g. DATE REC'D. BY REGISTRAR <b>APR 7 1982</b>		23h. REGISTRAR'S SIGNATURE <b>James J. Hartenstein</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 5.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 82 08841

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 82 08841	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis Wenceslaus SMETANA			2a. DATE OF DEATH MONTH DAY YEAR April 20, 1982		2b. HOUR 9:10 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman	12b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Joseph SMETANA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-46-1087		17. INFORMANT (NAME) ADDRESS Mrs. Evelyn A. Smetana Bel Air, Md. 21014	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4824 DUE TO, OR AS A CONSEQUENCE OF (b) Staph Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from April 16, 1982, to April 20, 1982, that (we) last saw the deceased alive on April 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Gersh, M.D.		DEGREE		22c. DATE SIGNED 4-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Gersh, M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 23, 1982	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR APR 23 1982		25b. REGISTRAR'S SIGNATURE	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08342

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. DATE OF ESTIMATE		4. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Charles		J.		Smith			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Male	White	July 8, 1917	64 YRS.			April 29, 1982	4:17 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U.S.A.		WIDOWED	DIVORCED		Baltimore County MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson	Greater Baltimore Medical Center		C.P.A. Johnston Laboratory				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Baltimore	Towson	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2 Buttrick Court, 21093			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Joseph A. Smith		Rose Hoffman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		Korean		Mrs. Frances J. <del>XXXX</del> Smith, Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:		Sudden					
IMMEDIATE CAUSE (a) 4100		Myocardial Infarction					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) Hypertensive ASCVD					
		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED	
Charles F. O'Donnell M.D.		Deputy				4/29/82	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Entombment		5-1-82		Dulaney Valley Mausoleum		Cockeysville, Maryland	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR	
Ruck Towson Funeral Home, Inc.		Towson, Md. 21204		1050 York Rd.		APR 30 1982	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 4 3 REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR		P. M.	
Christine Naomi Smith								April 18, 1982													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		MONTHS		DAYS		HOURS		MIN.			
Female		White		2 23 22		60															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Baltimore, Md.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. Baltimore County														MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Rosedale		7801 Bluegrass Road		Housewife		At Home															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Baltimore		Eastpoint		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7947 East Baltimore Street													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST		FIRST MIDDLE LAST																			
Louis W. Krebs		Christine Burkhardt																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS															
No		213-16-6454		Joseph F. Smith, Jr.		R.D. 2 Airville, Pa. 17302															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ce Pancreas a metastasis</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ce Pancreas a metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE										DEGREE										22c. DATE SIGNED	
T.A. F. Row										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										4-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS											
T.A. F. Row										223 Eastern Blvd. East, Md. 21221											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				4-21-82				Gardens of Faith				Overlea, Balto. Co. Md.									
24. FUNERAL DIRECTOR NAME										25a. DATE RECEIVED BY REGISTRAR										25b. REGISTRAR'S SIGNATURE	
C.S. Zeiler & Son Inc. 6224 Eastern Avenue										APR 20 1982										James	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08844

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM F. SMITH</b>			2a. DATE KNOWN OF DEATH MATED <b>April 12 1982</b>			2b. HOUR <b>9:20 PM</b>		
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 8 1905</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>April 12 1982</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b>		
10. CITY OR TOWN OF DEATH <b>Cockeysville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13612 Poplar Hill Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Murray Baumgartner</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Cockeysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>13612 Poplar Hill Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mark Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara E. Beaver</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		
16b. SOCIAL SECURITY NO. <b>215 07 9706</b>			17. INFORMANT <b>family records</b>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct Sudden</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <b>Generalized ASCVD 5+ yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Smith Coronary Artery</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <b>Charles F. Donnell, D. Deputy</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>4/13/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Evans Chapel of Chimes</b>			ADDRESS <b>2325 York Road</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/6/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. County, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Evans Chapel of Chimes</b>			ADDRESS <b>2325 York Road</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 14 1982</b>		
						25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 4 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE C. SMULLEN</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>4 24 82</b>				2b. HOUR <b>8:04 AM</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 11 08</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A-</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.										
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. CHARLES ST.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manufacture's Rep.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>										13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8513 Valleyfield Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Smullen</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Metzger</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>101-09-8859</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy N. Smullen 8513 Valleyfield Road</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4280</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b> <b>&gt; 1 YR</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 24</b> , 19 <b>82</b> , to <b>APRIL 24</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>APRIL 24</b> , 19 <b>82</b> , and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>J. Klugman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>4-25-82</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. J. KLIGMAN</b>				22e. ADDRESS <b>GBMC 6701 N. CHARLES STREET</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4-27-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>				23d. LOCATION <b>Baltimore</b> COUNTY <b>Maryland</b>									
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>				ADDRESS <b>1050 York Road Towson, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>San Nathan</b>							

GEORGE C. SMULLEN M W 6 11 08 73 4 24 82 8:04 P

BALTIMORE COUNTY

TOWSON GBMC 6701 N. CHARLES ST.

CHRONIC CONGESTIVE HEART FAILURE  
CARDIAC ARREST  
5 MIN

DR. J. KLIGMAN  
GBMC 6701 N. CHARLES STREET  
X XXXX APRIL 24 82  
X APRIL 24 82  
X APRIL 24 82  
X 4-25-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 4 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William D. SMYTHERS					2a. DATE OF DEATH April 16, 1982					2b. HOUR 4:40 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Steel Company				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1620 Williams Ave. 21221					
14. FATHER'S NAME FIRST MIDDLE LAST William C. Smythers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Stephenson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT Nancy Smythers		18. ADDRESS Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 16</u> , 19 <u>82</u> , to <u>April 16</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 16</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Ronald Attanasio</u>					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/16/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD ATTANASIO					22e. ADDRESS FRANKLIN SQUARE HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (EXCEPT) Cremation			23b. DATE 4-20-82		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR <u>Brzezinski Funeral Home</u>					25a. DATE REC'D. BY REGISTRAR APR 19 1982		25b. REGISTRAR'S SIGNATURE <u>Theresa J. Nathan</u>						

24. FUNERAL DIRECTOR

Brzezinski Funeral Home

ADDRESS

1407 Old Eastern Ave.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 4 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Karl F.W. Sorgeler</b>			7a DATE OF DEATH MONTH DAY YEAR <b>4 12 82</b>		7b HOUR <b>1:00 A.M.</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>3 17 09</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
10 CITY OR TOWN OF DEATH <b>Cetonsville</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Villa Nursing Home</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Fed. Govt. Army Corp Eng.</b>
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS <b>1448 Barrett Road</b> 21207
14 FATHER'S NAME FIRST MIDDLE LAST <b>Karl F. Sorgeler</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helena (Unknown)</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-30-6061</b>		17 INFORMANT <b>Karl A. Sorgeler</b> ADDRESS <b>Same as # 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardio Vascular</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 19 81</b> to <b>Apr 12, 19 82</b> , that (I) (we) saw the deceased alive on <b>4-9-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (I) (we) did not view the body after death.					
22b SIGNATURE <b>Harry L. Knipp, M.D.</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>4/13/82</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry L. Knipp M.D.</b>		22e ADDRESS <b>5411 Old Frederick Rd., Baltimore, Md. 21229</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b DATE <b>4/14/82</b>	23c NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore</b>	
24 FUNERAL DIRECTOR NAME <b>Witzke P.A.</b>		ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>		25a DATE REC'D. BY REGISTRAR <b>APR 16 1982</b>	
				25b REGISTRAR'S SIGNATURE <b>James J. Knipp</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frances F. Southerland</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>04/ 30/82</b>		2b. HOUR <b>3:00PM</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 29, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>607 Overbrook Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Claude Flemming</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Bidgood</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>225 12 5951A</b>		17. INFORMANT ADDRESS <b>Mr. Robert J. Southerland 607 Overbrook Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1749 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Cancer of Breast</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>04/28</b> , 19 <b>82</b> , to <b>04/30</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>04/30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>P. J. Patel</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patel P. J., M.D.</b>				22e. ADDRESS <b>GBMC 6701 N. Charles Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 5 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 4 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BERNICE SPARK BERNICE - SPARK						2a. DATE OF DEATH MONTH DAY YEAR 4-23-82				2b. HOUR 5:00 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 20, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. STATE MARYLAND		13b. COUNTY BALTO		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3234 SMITH AVE. (21208)			
14. FATHER'S NAME FIRST MIDDLE LAST SHALIA SPARK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-9521A		17. INFORMANT MR. ALLEN SPARK ADDRESS 3415 ENGLEMEADE RD. (21208)			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Cardio pulmonary arrest 20 to DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HASCVD with Myocardial Ischemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-25-1982 to 4-23-1982, that (I) (we) lost saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R.M. Shah						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-23-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH						22e. ADDRESS B.C.G.H. Old court RD. RANDALLSTOWN.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-25-82		23c. NAME OF CEMETERY OR CREMATORY TIFERETH-ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR APR 28 1982		25b. REGISTRAR'S SIGNATURE James J. Katten			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner(s) must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 2 0 8 8 5 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MAUDE SPICER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>4 10 82</b>				7b. HOUR MIN. <b>5 15</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 30 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.							
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi-Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse (retired)</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1006 F Woodson Rd.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Miller</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>545-46-2741</b>		17. INFORMANT ADDRESS <b>Dr. William S. Spicer, Jr. 11 Buchanan Rd.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA SITE OF ORIGIN</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>0</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 81</b> to <b>4/10 1982</b> , that (I) (we) last saw the deceased alive on <b>4/8 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)													
22b. SIGNATURE <b>James A. Quinlan, Jr.</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/10/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. QUINLAN, JR.</b>						22e. ADDRESS <b>UNIVERSITY HOSPITAL - BALTO, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glendale Calif.</b>							
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc., 6500 York Rd.</b>						ADDRESS <b>Balto. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 14 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 08851							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Raymond MIDDLE R. LAST Spriggs		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
RAYMOND		SPRIGGS		APRIL 22, 1982		10 <sup>25</sup>		A.M.	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
Male	Caucasian	April 16, 1899		83					
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b CITIZEN OF WHAT COUNTRY?	10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Baltimore County MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Catonsville	Forest Haven Nursing Home			Police Officer			Law Enfcmnt.		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland		---		Baltimore		13e STREET ADDRESS			
						101 W. Centre Street			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Spriggs		Catherine Engel							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		18 ADDRESS			
No		N/A		217-38-5672		Thelma Spriggs		3838 Roland Avenue Balto., Md. 21211	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pneumonia									
4360 DUE TO, OR AS A CONSEQUENCE OF Stroke									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-31, 1980, to 4/22, 1982, that (I) (we) last saw the deceased alive on 4/20, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
4/22/82		MD				4/22/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Harold B. B.		7220 Park Heights							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		4/23/82		Lake View Mem Pk.		Sykesville		Carroll, Md.	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MacNabb Funeral Home		Catonsville, Md.		APR 23 1982					

1102 BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 5 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Charles William SPRINGHAM			2a DATE OF DEATH MONTH DAY YEAR April 2, 1982		2b HOUR 3:00 p
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 8 - 10 - 1900		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH ROSEDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELLER	12b KIND OF BUSINESS OR INDUSTRY BANKING	
13a STATE MARYLAND	13b COUNTY BALTIMORE	13c CITY OR TOWN DUNDALK	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 7018 Apt. C MORNINGTON RD. 21222	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM SPRINGHAM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA SAFFIELD			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217.14.1759	17. HOME ADDRESS CHARLES WM. SPRINGHAM JR. 1707 MELBORNE RD. 21222			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension; senile dementia; Alzheimer's Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 5, 19 82, to April 2, 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 2, 19 82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Naeem Gauhar</i>		DEGREE MD		22c DATE SIGNED 4/2/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Naeem Gauhar		22e ADDRESS 9000 Franklin Square Dr., 21237			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 4/5/1982	23c NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24 FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222		25a DATE REC'D. BY REGISTRAR APR 5 1982		25b REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	

SECRET

CONFIDENTIAL

DATE  
NOTED  
ACTION

25

5

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 5 3 REG. NO.						
1. FOR STATE REGISTRAR					1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					2b HOUR	
					FIRST MIDDLE LAST Elsie M. STACHOWSKI					April 26, 1982					10:00 <sup>P</sup>	
3 SEX					4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS.			
F					W		MONTH DAY YEAR 7/15/16			65 YRS.			MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH	
MD					USA										Baltimore County MD	
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b KIND OF BUSINESS OR INDUSTRY	
ROSSVILLE					FRANKLIN SQ					HSWE						
13a STATE					13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS?		13e STREET ADDRESS				
MD					BALTO		PARKVILLE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7 DENDRON CT				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST WILLIAM KOCHANOWSKI					FIRST MIDDLE LAST JULIA DEMBECK											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS						
NO					216 01 1398		CHAS. STACHOWSKI			A ABOVE						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) <u>Renal Failure</u>																
3989 DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
(b) <u>Rheumatic Heart Disease</u>																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
					HOUR A.M. MONTH DAY YEAR P.M. 19											
21d INJURY OCCURRED					21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE								
22a I certify that (X) (this hospital) attended the deceased from March 20, 19 82, to April 26, 19 82, that (X) (we) last saw the deceased alive on April 26, 19 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.																
22b SIGNATURE										DEGREE		22c DATE SIGNED				
Chris Berchelmann M.D.										M.D.		4/26/82				
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS						
Chris Berchelmann										9000 Franklin Square Drive 21237						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)					23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION						
BURIAL					4/30/82		MORELAND'S			BALTO. MD						
24 FUNERAL DIRECTOR										25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE		
J.G. CONNELLY										APR 28 1982				Name Jan Math		
NAME ADDRESS																
300 MACE																

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APR 28 1914

11/12/14

11/12/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 5 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NELLIE IRENE STARNER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>April 4, 1982</b>				2b. HOUR <b>6:08a M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 12, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>811 Wheel Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Green Hooper</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Lee League</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-18-2514</b>		17. INFORMANT ADDRESS <b>Baltimore, Md. Mrs. Evelyn I. Bailowich, 22 Harrison Blvd.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiorespiratory Arrest, Acute and</b> <b>2554</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Peritonitis, Hemorrhagic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adrenal Infarction, Bilateral Pleural Effusion</b> DUE TO, OR AS A CONSEQUENCE OF (approximately 1 liter each side) (c) <b>(side)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 27</b> , 19 <b>82</b> , to <b>April 4</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 4</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.													
22b. SIGNATURE <b>Matthew Scott</b>				DEGREE <b>Scott</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-4-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Matthew Scott</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 8, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Emmorton Harford Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md.</b>						25a. DATE REC'D. BY REGISTRAR (25) REGISTRAR SIGNATURE <b>APR 8 1982 Thomas Jan Nathan</b>							

MEDICAL CERTIFICATION

1 2 3 4 5 6 7 8 9 10 11 12

11/1

Handwritten signature or initials.

APR 18 1945

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 0 8 8 5 5

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN G STEES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4/26/82</b>		2b. HOUR <b>7:20 PM</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-29-1909</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co. MD.</b>		
10 CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cartoonist</b>	12b KIND OF BUSINESS OR INDUSTRY <b>News</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Lutherville</b>			13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <b>103 W. Seminary</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John O. Stees</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luella Grove Stees</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-03-2380</b>	17 INFORMANT ADDRESS <b>103 W. Seminary Ave Lutherville, Md.</b>			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CANON pulmonary Cancer</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEPATIC Myocardial Infarct</b>	<b>acute</b>
	DUE TO, OR AS A CONSEQUENCE OF (c) <b>HAZARD</b>	<b>20 yrs</b>
	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>HAZARD</b>	

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that I (this hospital) attended the deceased from <b>8/1/13</b> 19 <b>74</b> to <b>2/26</b> 19 <b>82</b> that I (we) saw the deceased alive on <b>4/23</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state did not view the body after death.)			
22b. SIGNATURE <b>Richard M. Maffezoli</b>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>4/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR R MAFFEZOLI</b>		22e ADDRESS <b>660 KENILWORTH DR BALT 21204</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b DATE <b>4/27/1982</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cratin &amp; Ferris</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>West Chester, Chester, Pa.</b>
24 FUNERAL DIRECTOR NAME <b>Kenneth G. Orshurn, P.R. Inc.,</b>		25 MAY REC'D BY HEALTH DEPT. 3 1982	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 5 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>NELLIE C STEGMAIER</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>4 10 82</i>		2b. HOUR <i>10 00 PM</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 2, 1892</i>		6. AGE IN YEARS (LAST BIRTHDAY) <i>89</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hospital Home Maker</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Villa Nova</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>4121 Buckingham Road 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Laughlin</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Ann Hobin</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>267-41-5665</i>		17. INFORMANT <i>Mrs. Angela M. Schotta</i> <i>4121 Buckingham Road Baltimore, MD. 21207</i>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 2501 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus with Ketoacidosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Decubitus ulcer</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-21-82</i> to <i>4-10-82</i> . That (I) (we) last saw the deceased alive on <i>4-10-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Soonchul Hong</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4-10-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SOONCHUL HONG</i>		22e. ADDRESS <i>Baltimore County General Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>	23b. DATE <i>4-10-82</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Queen of Heaven Maus.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>N. Lauderdale Broward Fla.</i>	
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, Inc.</i> ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 13 1982</i> REGISTRAR'S SIGNATURE <i>Charles J. Nathan</i>			

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1985

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 5 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>REBECCA STEIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 28 82</b>		2b. HOUR <b>9 17 PM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 XXX 1985</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		
10 CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>			
13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>PINCUS SCHERR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CYRILE UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-44-7538</b>		17. INFORMANT <b>MR. SOLOMON STEIN</b> <b>3 STONEHENGE CIR., APT. 9 #21208</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA WITH SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4860</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>ARTERIOSCLEROTIC HEART DISEASE, RENAL FAILURE</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION <b>4-27-1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ARTERIOSCLEROTIC HEART DISEASE, RENAL FAILURE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>---</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>4-27-1982</b> to <b>4-28-1982</b> , that (I) (we) last saw the deceased alive on <b>4-28-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Sudhir D. Patel</b>		DEGREE <b>---</b>		22c. DATE SIGNED <b>4-28-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR SUDHIR D. PATEL</b>		22e. ADDRESS <b>Bal County Gen. Hosp.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 30, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>AITZ CHAIM</b>		
23d. LOCATION <b>BALTIMORE</b>		COUNTY <b>MARYLAND</b>				
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 4 1982</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>						

MEDICAL CERTIFICATION

18021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
Brenda Jean STILES								April 6, 1982		6:15 P	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Female		White		6 3 1956		25 YRS					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
Maryland		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville		Franklin Square Hospital				Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		BALTIMORE		Baltimore		YES		6928 Conley Street			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Donald R. Kramer, Sr.				Ima J. Ward							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		213-78-2575		Ira M. Stiles		6928 Conley Street Balto. MD 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7100 DUE TO, OR AS A CONSEQUENCE OF Pseudomonas sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Fulminating systemic lupus erythematosus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) this hospital attended the deceased from March 21, 1982, to April 6, 1982, that (we) last saw the deceased alive on April 6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE Steven Snyder M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/6/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Snyder MD						22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		4/9/82		Holly Hill Memorial		White Marsh, Balto., Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, Maryland 21222						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						APR 13 1982					

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Handwritten signature or text, possibly "K. H. H."

Handwritten signature or text, possibly "J. H. H."

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by note.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 5 9

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Barbara C. STOEWER		April 30, 1982		6:39 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	Sept 13 1919	62 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Franklin Square Hospital	Secretary	Shillcraft		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4322 Parkside Drive	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
George Dannenfelser	Bessie Benda	no			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
220-03-2823	William Stoewer (husband)	same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Electromechanical dissociation					
4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute inferior myocardial infarction					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Hypertension; peptic ulcer disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 29, 1982, to April 30, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 30, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
K. Yamamoto		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		4/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
K. Yamamoto		9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	CITY OR TOWN	COUNTY STATE
Burial	5/4/82	Parkwood	Baltimore		Md.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Schimunek Funeral Home, Inc.		MAY 4 1982		James VanNathan	
3331 Brehms Lane, Balto. Md. 21213					

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*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. The text is too light to transcribe accurately.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 08860							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHESTER HERBERT STONE					2a. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1982			2b. HOUR 7:15 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi Medical Convalescent Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Freight Agent		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3919 Cloverhill Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Stone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Blanche Springer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-05-7848		17. INFORMANT Mr. Snowden Haff			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABCD</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Senile dementia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9</u> 19 <u>77</u> to <u>10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>G. William Benedict, M.D.</u>					DEGREE		22c. DATE SIGNED 4/4/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. William Benedict, M.D.					22e. ADDRESS 2 W. University Parkway Baltimore, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR. 14, 1982		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY, MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. BALTO., MD. 21212					25a. DATE REC'D. BY REGISTRAR APR 10 1982				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DHMH-16 50M 1/B1  
(VRA 15, 4)FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 8 6 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LA RUE RADOLIFF STROMBERG			2a. DATE OF DEATH MONTH DAY YEAR 4-30-82			2b. HOUR 2 10 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 29 94		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Patonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. CITY OR TOWN Howard		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 3673 PARK AVE	
14. FATHER'S NAME FIRST MIDDLE LAST Charles P. Radcliffe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Shipley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 214 38 7078		17. INFORMANT 92155 Benger Rd. Doris S. Thompson Columbia, Md 21046					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic ht. dis. ± 10 y. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/30/82 to 4/30/82, and that in (my) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) sign the body after death.							
22b. SIGNATURE C. S. MASS		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. S. MASS		22e. ADDRESS 413 Nottingham Rd. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-3-82		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Elliott City Howard Md.	
24. FUNERAL DIRECTOR NAME Slack Funeral Home		ADDRESS Elliott City Md 21043		25a. DATE REC'D. BY REGISTRAR MAY 4 1982		25b. REGISTRAR'S SIGNATURE Charles J. Nathan	

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08862	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAYMOND A. STUBLER JR.</b>										2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>4 14 19 82</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 31 37</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>45 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>45</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 14 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>	
10. CITY OR TOWN OF DEATH <b>BALTO. HGLDS.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2923 Alabama Avenue DOA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DELIVERY MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MESSENGER</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTO. HGLDS.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2923 ALABAMA AVENUE, 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>RAYMOND A. STUBLER SR.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOROTHY E. GOODMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>217-30-3743</b>		17. INFORMANT ADDRESS <b>RAYMOND A. STUBLER, SR. 1208 POPLAR AVE. 21227</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>5718 IMMEDIATE CAUSE (a) Fatty change of liver</b> Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Hormez R. Guard</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>4/14/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>				23b. DATE <b>04-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 16 1982</b>		25b. REGISTRAR'S SIGNATURE <i>J. J. Jones</i>			

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*John*

APR 10 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 08863

1 DECEASED NAME (TYPE OR PRINT) <b>Elizabeth F. Stumpf</b>			2a DATE OF DEATH MONTH DAY YEAR <b>APRIL 23, 1982</b>			2b HOUR M <b>AM</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 28, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79</b>		7 UNDER 1 YEAR HOURS MIN. <b>0 0</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>400 REGESTER AVENUE</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b KIND OF BUSINESS OR INDUSTRY <b>BANK</b>		
13a STATE <b>MD.</b>			13b CITY OR TOWN <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>400 REGESTER AVE. 21212</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>LORENZE EISEL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE BOPP</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-01-4776B</b>		17 INFORMANT ADDRESS <b>WILLIAM STUMPF JR. 400 REGESTER AVE. 21212</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 20, 1982</b> to <b>April 23, 1982</b> , that (I) (we) lost saw the deceased alive on <b>April 19, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE <b>L. Myrton Gaines Jr.</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		17d. DATE SIGNED <b>4/23/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. MYRTON GAINES JR.</b>			22e. ADDRESS <b>7800 YORK RD.</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>APR. 26, 1982</b>		23c NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY MEM. Gdns. COCKEYSVILLE</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO, MD.</b>			
24 FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFEELD HOME</b>			ADDRESS <b>6500 YORK RD. 21212</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 27 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

U. C. P. 25

CHICAGO, ILL. 60607

TO THE EDITOR

DEAR SIR

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 6 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Coy Leon Swisher			2a. DATE OF DEATH MONTH DAY YEAR April 11 82			2b. HOUR 12 25 P.M.			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 11 26 1923		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Motion Picture Producer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 112 Ardoon Road 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Earl Swisher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isa Fern Hoff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Lutherville, Md. #21093 Virginia C. Swisher, 112 Ardoon Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aspiration pneumonia 1509 DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal reflux 2 + yrs 3 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 4-3-82, to 4-11-82, that (1) (we) lost saw the deceased alive on 4-11-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wm Carl Eseling MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-11-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm CARL ESELING MD				22e. ADDRESS 7401 Osceola Dr Baltimore					
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial		23b. DATE 4/14/1982		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Maryland			
24. FUNERAL DIRECTOR Lemmon-Mitchell-Wiedefeld				25a. DATE REC'D. BY REGISTRAR APR 13 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 6 5  
REG. NO.

1 - FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
		BERTHA E. TANKERSLEY		APR. 25, 1982		M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
F		W		1/17/20		62	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MD.		USA				BALTO. COUNTY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
ESSEX		630 DELAWARE AVE		HSEW			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD		BALTO		MIDDLE SEX		3535 HONEYSUCKLE LN.	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.	
JOHN CRAMBLITT		SARAH UNK		NO		UNK	
17 INFORMANT ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PATRICIA REESE 911 BARRON AVE		4140 Cardiac arrest		Immed			
		4140		4 YRS			
		Diabetes mellitus; Coronary bypass 2/17/81					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Jan 24, 1981, to April 19, 82, that (I) (we) last saw the deceased alive on April 19, 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) did not view the body after death.		22b SIGNATURE DEGREE		22c DATE SIGNED			
		Louis Semenov		4/27/82			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
LOUIS SEMENOFF		2108 OREMSB BAPT MDZ1220		BURIAL		4/28/82	
				23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
				OAK LAWN		BALTO. MD	
24 FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.G. CONNELLY 300 MACE		APR 28 1982		[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR		7		8 2 0 8 8 6 6		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		TAWNEY Sr.		2a DATE OF DEATH		2b HOUR	
BOSLEY C.		C.		Tawney		4-1-82		2:20p	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Male		White		March 8, 1900		82		82	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 MD.	
Maryland		U.S.A.				BALTIMORE COUNTY			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL		Machine Operator		Tool			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland		Baltimore		21234		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8707-D Raven Drive	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
John Thomas Tawney		Mary Eliza Kirkpatrick		No		717-07-9000		Bosley C. Tawney, Jr. Towson, MD 21204	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		18c CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4360		717-07-9000		Bosley C. Tawney, Jr. Towson, MD 21204		CEREBROVASCULAR ACCIDENT			
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		ARTERIOSCLEROTIC VASCULAR DISEASE		CHRONIC OBSTRUCTIVE PULMONARY DISEASE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		CORD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		SEIZURES, PNEUMONIA							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
March 19, 82		Bladder tumor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from		22b SIGNATURE		DEGREE		22c DATE SIGNED			
March 19, 82		Stephen Bush		MD		4/1/82			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE REC'D BY REGISTRAR		22g REGISTRAR'S SIGNATURE			
Stephen Bush		600 W Northern Pkwy		APR 2 1982		Frances Jan Nathan			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Burial		Apr. 5, 82		Grace U.M. Church		Baltimore Co., MD			
24 FUNERAL DIRECTOR		24b ADDRESS		24c DATE REC'D BY REGISTRAR		24d REGISTRAR'S SIGNATURE			
William E. Johnson		8521 Loch Raven Blvd.		APR 2 1982		Frances Jan Nathan			

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "TO", "FROM", and "DATE" are visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR XC 11 285 993									
1. DECEASED NAME (TYPE OR PRINT) THOMAS JOSEPH TEW SR.						2a. DATE OF DEATH APRIL 16, 1982		2b. HOUR 12:05 A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 27, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A.M.C., FORT HOWARD, MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSEMAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN MIDDLE RIVER 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 9610 CONMAR ROAD									
14. FATHER'S NAME JOHN L. TEW					15. MOTHER'S MAIDEN NAME EDNA TURNER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 243 18 2109		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 1									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1982, to APRIL 16, 1982, that (I) (we) lost saw the deceased alive on APRIL 16, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ashok Kumar Chopra M.B.B.S.						DEGREE M.B.B.S.		22c. DATE SIGNED 4/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASHOK K. CHOPRA, M.D.						22e. ADDRESS VAMC, FORT HOWARD, MARYLAND 21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/19/82		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN BALTO. COUNTY MD STATE			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY ADDRESS 300 MACE						25a. DATE REC'D. BY REGISTRAR APR 21 1982		25b. REGISTRAR'S SIGNATURE James Van Natta	

MEDICAL CERTIFICATION

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SSR, JS, JSTL

W. A. R. • • • FORT HOWARD, CALIF.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 08868

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMILY M THOMAS			2a. DATE OF DEATH MONTH DAY YEAR 4 4 82		2b. HOUR 4 23 PM
3. SEX F	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 12 17 09	6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		# UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN Parkville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1511 Taylor Ave	
14. FATHER'S NAME FIRST MIDDLE LAST Philip J. Shimer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna J. Slama			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-14-589	17. INFORMANT ADDRESS Family Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5698 IMMEDIATE CAUSE (a) <u>Cardinal Abscess</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infected Wound</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Kidney Disease - Prolonged Therapy</u>					
19a. DATE OF OPERATION 3/31/82	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Infected Wounds	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 3/15, 19 82, to 4/4, 19 82, that (I) (the hospital) saw the deceased alive on 4/4, 19 82, and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did) (did not) view the body after death.					
22b. SIGNATURE Charles B. Hatton MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/4/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES HATTON		22e. ADDRESS 7600 OSLER DR. TOWSON, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/8/82	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		
24. FUNERAL DIRECTOR NAME Evans Chapel		25a. DATE REC'D. BY REGISTRAR APR 14 1982	25b. REGISTRAR'S SIGNATURE James J. Nathan		

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 0 8 8 6 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arthur E. Thompson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 11 82</b>		2b. HOUR <b>7: P M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 24 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>92</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>York, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County MD</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baptist Home of Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Maryland Balto. Owings Mills 4508 Elstrode Ave 21214</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Thompson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie C. Markley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>717-07-7897</b>		17. INFORMANT ADDRESS <b>Records of Baptist Home 10729 Park Hgts. 21117</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____			
22a. I certify that (I) (the hospital) attended the deceased from <b>JUNE 19 81</b> to <b>APRIL 19 82</b> , that (I) (the hospital) saw the deceased alive on <b>APRIL 8 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.							
22b. SIGNATURE <b>John G. Lavin</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/13/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John G. Lavin</b>				22e. ADDRESS <b>6805 YORK RD; BALTIMORE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>april 14, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemtery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell- Wiedefeld 6500 York Rd.</b>				25a. DATE REC'D BY REGISTRAR <b>APR 16 1982</b>		25b. SIGNATURE <b>[Signature]</b>	

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1890  
Office of the  
Commissioner of  
the General Land  
Office  
Washington, D.C.  
April 10, 1890  
To the  
Honorable  
Commissioner of  
the General Land  
Office  
Washington, D.C.  
Dear Sir:  
I have the honor to  
acknowledge the receipt  
of your letter of the  
10th inst. in relation  
to the application of  
the National Land  
Office for the  
purchase of the  
land in the  
County of  
Washington, D.C.  
and in reply to  
advise you that the  
same has been referred  
to the proper  
authorities for their  
consideration.  
Very respectfully,  
Your obedient servant,  
John W. Foster,  
Commissioner of the  
General Land Office.

1890  
Office of the  
Commissioner of  
the General Land  
Office  
Washington, D.C.  
April 10, 1890  
To the  
Honorable  
Commissioner of  
the General Land  
Office  
Washington, D.C.  
Dear Sir:  
I have the honor to  
acknowledge the receipt  
of your letter of the  
10th inst. in relation  
to the application of  
the National Land  
Office for the  
purchase of the  
land in the  
County of  
Washington, D.C.  
and in reply to  
advise you that the  
same has been referred  
to the proper  
authorities for their  
consideration.  
Very respectfully,  
Your obedient servant,  
John W. Foster,  
Commissioner of the  
General Land Office.

NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 7 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELLA THORINGTON</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>04 28 82</b>		2b. HOUR <b>7<sup>30</sup> A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 04 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>79</b>		IF UNDER 24 HRS <b>79</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>27 TANGLEWOOD ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>27 TANGLEWOOD ROAD, 21228</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT A. THORINGTON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLA UNKNOWN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-01-1872</b>		17. INFORMANT ADDRESS <b>GEORGE H. SHAW 23 N. SYMINGTON AVENUE 21228</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DEHYDRATION</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ORGANIC BRAIN SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>BILATERAL STROKES</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>1/81</b> <b>1/81</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PARANOID IDEATION; DECUBITUS ULCER</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> , 19 <b>81</b> , to <b>4/28</b> , 19 <b>82</b> , that (I) (we) saw the deceased alive on <b>4/19</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Walter J. Alt, M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/29/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER J. ALT, M.D.</b>						22e. ADDRESS <b>301 MARYDELL ROAD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>04-30-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALISBURY WICOMICO MARYLAND</b>							
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 30 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. North</b>					

0 1 8 8 0 2 4

APR 20 1960  
J. B. O'Connell

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08871			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert W. Thumma SR.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 12 19 82		2b. HOUR M 1:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-12-28 53 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 12 19 82		2d. HOUR P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethlehem Steel Dispensary				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSE MAN		12b. KIND OF BUSINESS OR INDUSTRY BETH STEEL			
13a. STATE MD				13b. CITY OR TOWN BALTO				13c. STREET ADDRESS 310 S. REGISTER ST					
14. FATHER'S NAME FIRST MIDDLE LAST MITCHELL THUMMA						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVE RODKEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 217-24-5679		17. INFORMANT ADDRESS HELER THUMMA 310 S REGISTER ST							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 4-13-82					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 4-16-82		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS BALTO				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR NAME JOHN M. WEBER				ADDRESS 401 S. CHESTER ST		25a. DATE REC'D. BY REGISTRAR APR 14 1982				25b. REGISTRAR'S SIGNATURE James J. Nathan			

1880

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 7 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Effie Mae Torres</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>April 3, 1982</b>			2b. HOUR M		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 17, 1928</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>53</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			MD.		
10 CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1631 Gray Haven Court 21222</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1631 Gray Haven Court 21222</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Stoner</b>						15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>Edna Sawyer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Mr. Adrian C. Torres 1631 Gray Haven Ct.</b>							
16a. <b>NO</b>		16b. <b>069-32-4517</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SCYAMOUS CER. CARCINOMA RT LYNG</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>David J. Seff MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/4/82</b>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID J. SEFF MD</b>						22e. ADDRESS <b>100 N. BROADWAY, BALTO MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>April 7, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hills</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Balto. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thane Jan. Hester</b>			

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Handwritten notes at the bottom of the page, including the word "LAW" and other illegible scribbles.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 8 7 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
SAM P TRICARIO				4-13-82				4:40am	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
Male		White		Sept. 21, 1910		71 YRS.		Maryland	
7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
U.S.A.				BALTIMORE COUNTY				MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL				Steel			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		BALTIMORE		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2521 Wendover Road	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Carlo		Tricario		Josephine		Pardo			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
Yes		WW II		216-09-4305		Mrs. Shirley Meninger		5128 Farnsworth Place	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4100		Cardio pulmonary arrest							
DUE TO, OR AS A CONSEQUENCE OF		(b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Ischemic heart disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19b, PART 1, OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased (or saw the deceased alive on 4-13-82) and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.		4-13 19 82		4-13 19 82		that (X) (we) last			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
E. NAKHODA		MD.							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
E. NAKHODA		7620 YORK ROAD TOWSON MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		4-16-82		Parkwood Cemetery		Baltimore		Maryland	
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		APR 14 1982		James J. Kistner					
Leonard J. Ruck, Inc. 5305 Harford Rd. 21214									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 8 7 4  
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Evelyn B. Trimble</b>			April 20, 1982			11:00 P M		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 24, 1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Glenarm</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11800 Harford Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Glenarm</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>11800 Harford Road</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Burnup</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Moffett</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-05-1211</b>		17. INFORMANT ADDRESS <b>Edgar Lee Trimble 11800 Harford Road</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1749 Carcinoma Breast c</b> IMMEDIATE CAUSE (a) <b>Metastases</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CO.P.D.</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>CO.P.D.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1975, to April 20, 1982, that (I) (we) last saw the deceased alive on April 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Donald W. Mintzer, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/23/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald W. Mintzer, M.D.</b>				22e. ADDRESS <b>3009 Evergreen Ave. Baltimore, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 24, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 23 1982</b>				

4 7 8 0 2 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 0 8 8 7 5

1. DECEASED NAME (TYPE OR PRINT) JAMES LEROY TRONE J.F.D.D.S.		2a. DATE OF DEATH MONTH DAY YEAR April 15, 1982		2b. HOUR 9:57a	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH BALTO. CO. MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DENTIST		12b. KIND OF BUSINESS OR INDUSTRY DENTISTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY HARFORD		13c. CITY OR TOWN HAYREDE GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS BAYVIEW DRIVE, EXT.	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES LEROY TRONE SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERNA SIMMONS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 217-18-8183		17. INFORMANT ADDRESS THE MARGARET C. TRONE, SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hematoma 4310 DUE TO, OR AS A CONSEQUENCE OF (b) Possible Septic Emboli DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION 4/13/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracerebral Hematoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 13, 1982, to April 15, 1982, that (I) (X) lost saw the deceased alive on above (I) (X) (did) (did not) view the body after death.					
22b. SIGNATURE Panayiotis L. Sitaras MD		DEGREE MD		22c. DATE SIGNED 4-15-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PANAYIOTIS L. SITARAS		22e. ADDRESS 1800 BRADDOCK RD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4-82		23c. NAME OF CEMETERY OR CREMATORY CRATIN & SONS	
23d. LOCATION CITY OR TOWN COUNTY WESTCHESTER, WESTCHESTER PA		25a. DATE REC'D. BY REGISTRAR APR 22 1982			
24. FUNERAL DIRECTOR NAME MITCHELL F.H. PA. HAYREDE GRACE, MD.		25b. REGISTRAR'S SIGNATURE Theresa J. [Signature]			

MEDICAL CERTIFICATION

2 8 8 0 8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17  
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 7 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JULIA M. TURNBAUGH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 30 '82</b>		2b. HOUR <b>2:20A<sub>M</sub></b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 04 '07</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>DRUG STORE</b>	
13a. STATE <b>MO.</b>			13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>LOCKYSSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES E. HOWARD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH E. SHEELER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216094929</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b> <b>3 DAYS</b> <b>4/26/82</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-30</b> , 19 <b>82</b> , to <b>4-30</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>4-30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John Steinberg MD</b>		DEGREE		22c. DATESIGNED <b>4/30/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. STEINBERG, M.D.</b>		22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAY 3 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>TIMONUM BALTO-MO.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPLOF CHMSS 2325 YORK ROAD</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>James VanNatten</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 7 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Earl R Uhlhorn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 19, 1982</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 3, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Parkville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>2605 Harwood Rd</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William A Uhlhorn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie L Seitz</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-10-7045</b>		17. INFORMANT ADDRESS <b>Mrs Bette Langley 10631 Jones Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROTIC CARDIOVASCULAR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ACUTE TONSILLOPHARYNGITIS AND DEHYDRATION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAR. 19, 1979</b> to <b>APR. 19, 1982</b> , that (I) (we) lost saw the deceased alive on <b>APR. 19, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Fausto Q. Aquino IV, MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4-22-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Fausto Aquino M.D.</b>			22e. ADDRESS <b>8713 Harford Rd Baltimore, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/22/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>			25a. DATE REC'D. BY REGISTRAR IN REGISTER <b>APR 22 1982</b> <i>James J. [Signature]</i>		

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

CONSTITUTIONAL RIGHTS

ARTICLE 3 - LEGISLATIVE

SECTION 1

ALL LEGISLATIVE POWERS SHALL BE VESTED IN A CONGRESS

SECTION 2 - CLERK OF THE HOUSE

SECTION 3 - SENATE

SECTION 4 - JUDICIAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08878

1- FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		3. DATE OF DEATH		4. DATE OF DEATH		5. DATE OF DEATH		6. DATE OF DEATH	
OLEY		XROOK		VANCE							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.
Male	White	4 19 27	54 YRS.			4 11 82			19 82	2100	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. NEVER MARRIED	10. WIDOWED	11. DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	U.S.A.					Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Eastwood	7210 Gough Street	Electrician		Beth Steel							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
Maryland	Baltimore	Eastwood	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7210 Gough Street 21224							
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Asa	Florence	219-20-6035		Louise E. Vance		7210 Gough Street					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	18b. SOCIAL SECURITY NO.	19. INFORMANT		ADDRESS							
Yes	?	219-20-6035		Louise E. Vance		7210 Gough Street					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Chronic ischemic myocardial disease DUE TO, OR AS A CONSEQUENCE OF Chronic hypertensive cardiovascular disease (b) 5 yr. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
J. Crossan O'Donovan		Deputy		4/11/82							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE					
J. CROSSAN O'DONOVAN		2112 Dundalk Ave., Balb., Md. 21222		APR 13 1982		Anne J. [Signature]					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE					
Burial	4-15-82	Vance Cemetery		Oregon, Pendleton Co., W. Va.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
C.S. Zeiler & Son Inc. 6224 Eastern Avenue		APR 13 1982		Anne J. [Signature]							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 AND 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 2 0 8 8 7 9

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN MILTON VINUP</b>				2a. DATE KNOWN OF ESTI. DEATH MATED <input type="checkbox"/> MONTH DAY YEAR 19 <b>April 4 1982</b>				2b. HOUR M <b>1132</b> M					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JUL 11 1900</b>		6 AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>81</b>		7c. DATE PRONOUNCED DEAD <b>April 4 1982</b>		7d. HOUR M <b>1132</b> M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH <b>Balto.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN MARYLAND, GIVE STREET ADDRESS) <b>Franklin Square Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK IF MOST OF YEAR'S LIFE) <b>Custodian</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>103 EASTERN AVE ESSEX 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John G. Vinup</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Prell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-09-7823</b>				17. INFORMANT ADDRESS <b>John Vinup 23102 Nona, Dearborne, Mich. 48124</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <b>DISEASE</b> (c) <b>DISEASE</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Paul K. Guerin</b>				TITLE (SPECIFY) M.D. <b>DEPUTY</b>				DATE SIGNED <b>4/5/82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL K GUERIN</b>				ADDRESS <b>1311 WESTERN RD COCKEYSVILLE MD 21030</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-8-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL HOME NAME ADDRESS <b>Schimineck Funeral Home, Inc. 3331 Brehms Lane 21213</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Winters</b>					

MEDICAL CERTIFICATION

0000 BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 8 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY THERESA VOSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-5-82</b>		2b. HOUR <b>11:00am</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 26, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>75</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Lady</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS <b>8326 Hillendale Road</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Richard Voss</b>						
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Agnes Graley</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>						
16b. SOCIAL SECURITY NO. <b>216-22-3877</b>		17. INFORMANT ADDRESS <b>Marie A. Dasch Baltimore, MD 21234</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4-2</b> , 19 <b>82</b> , to <b>4-5</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4-5</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.								
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-6-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>REYNALDO ORJUELA-GOMEZ, M.D.</b>				22e. ADDRESS <b>7620 YORK ROAD TOWSON MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 8, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD</b>		
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>				ADDRESS <b>8521 Loch Raven Blvd.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 7 1982</b>		
						25b. REGISTRAR'S SIGNATURE 		

0 8 9 9

DATE: 12-1-1961

*[Handwritten signature]*

APR 7 1962  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 8 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH J. WALKER			2a. DATE OF DEATH MONTH DAY YEAR 4 24 82		2b. HOUR 6:01 P.M.
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 11 2 11		6. AGE (IN YEARS LAST BIRTHDAY) 70	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Towson, Maryland		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION GREATER BALTIMORE MEDICAL CTR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. CITY OR TOWN Sparrows Pt.	13c. STREET ADDRESS 2801 Sparrows Pt. Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST James Walker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-8260		17. INFORMANT ADDRESS Jennie Walker 2801 Sparrows Pt. Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 1509 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGIAL CANCER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 2		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ESOPHAGIAL TUMOR		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 24 19 82 to APRIL 24 19 82, that (I) (we) lost saw the deceased alive on APRIL 24 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward P. Grace M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> XX		22c. DATE SIGNED 4-24-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EDWARD GRACE		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/28/82	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Whitemarsh, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H		1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR APR 26 1982	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DOI: 10.1002/for

100

1119

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 8 2

REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Walter Alpha WARD		2a DATE OF DEATH MONTH DAY YEAR April 3, 1982		2b HOUR 6:50P M	
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 9/22/00		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY BARBER			
13a STATE MD.		13b COUNTY BALTO		13c CITY OR TOWN ESSEX		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 525 DORSEY AVE	
14 FATHER'S NAME FIRST MIDDLE LAST HARVEY J. WARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RE BECCA J. CREW		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236 018271		17 INFORMANT ADDRESS ALMA WARD ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic vascular disease</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (X) (this hospital) attended the deceased from April 3, 19 82, to April 3, 19 82, that (X) (we) last saw the deceased alive on April 3, 19 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE K. Rothbaum, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 4/3/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) K. Rothbaum M.D.				22e ADDRESS 9000 Franklin Square Dr., 21237					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 4/6/82		23c NAME OF CEMETERY OR CREMATORY HOLLY HILL CEM.		23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24 FUNERAL DIRECTOR NAME Connolly F.H.				24b ADDRESS 300 Mace ave		25a DATE REC'D. BY REGISTRAR APR 6 1982		25b REGISTRAR'S SIGNATURE James J. Nathan	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 8 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
May Pearl WARNER		Female		White	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Oct 22, 1894		87		YRS. MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		Baltimore County MD.		Rossville	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Franklin Square Hospital		Housewife			
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Columbus A Hartsock		Winifred Deffenbaugh		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c)	
216-05-3204		Mr Frank Hartsock 1638 Shadyside Rd		4249 (a) Cardiopulmonary Arrest	
				(b) Congestive Heart Failure	
				(c) Cardiac Valvular Disease	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from April 3, 19 82, to April 15, 19 82, that (we) lost saw the deceased alive on April 15, 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Richard D. Del Pero M.D.		M.D.		4/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
Richard Del Pero M.D.		9000 Franklin Square Drive 21237		Burial	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
4/17/82		Moreland Mem Park		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DEED RECORD BY RECORDS AND REGISTRAR SIGNATURE		25b. DEED RECORD BY RECORDS AND REGISTRAR SIGNATURE	
Leonard J Ruck Inc. Baltimore, Maryland		21214		APR 16 1982	

1895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 8 4			
1- FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Jerome		Warshawsky						April		9	-	1982	8:30 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		APRIL 3, 1928		54							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA				Baltimore County MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR							
RANDALLSTOWN		BALTIMORE COUNTY GEN. HOSP.		SALESMAN		AUTOMOBILE							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
MARYLAND		BALTIMORE		PIKESVILLE				2710 SMITH AVE. (21209)					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
NATHAN		WARSHAWSKY		DUBBYE		BLUM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES WWII		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NAVY		220-22-1479		MRS. RITA WARSHAWSKY		2710 SMITH AVE. (21209)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4100		IMMEDIATE CAUSE (a) Acute Myocardial Infarction		How									
DUE TO, OR AS A CONSEQUENCE OF		(b) CORONARY Arterio Sclerosis, severe, & Thrombosis		years									
DUE TO, OR AS A CONSEQUENCE OF		(c)		Recent (HRS)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from April 19 68 to April 9 19 82, that (I) (we) lost saw the deceased alive on 4-9-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
David I. Miller		M.D.				4-9-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
David I. Miller M.D.		10209 S. Delwood Rd. Catonsville, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		STATE					
BURIAL		4-11-82		BETH EL MEM. PARK		RANDALLSTOWN, MD.		MD					
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
SOL LEVINSON & BROS.		APR 15 1982		James Van Natten									
6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)													

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2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 8 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Pauline E. Waters		April 24, 1982		4:15 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
female	white	Sept. 11, 1913		68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Pennsylvania		U.S.A.		Baltimore County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Randallstown		Old Court Nursing Center		Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Balto.		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
John		Sarah Margaret Allan		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of breast</u>	
162-12-7787		Mr. Thomas Waters Baltimore, Md. 21207		1749	
19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> 19 <u>82</u> to <u>4/24</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JEROME GINSBERG, M.D.		5310 OLD COURT ROAD 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/28/82		Woodlawn Cemetery	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Woodlawn		Balto.		MD STATE	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers Funeral Directors		APR 27 1982		Charles J. Nathan	
8728 Liberty Rd. Randallstown, Md. 21133					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 8 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HOWARD J. WEEKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 12, 1982</b>		2b. HOUR <b>8:48 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>03 12 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MINNESOTA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>ESSEX</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OIL BURNER MECH-ANIC</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>DUNDALK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEWIS EDWIN WEEKS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHRINE MARTIN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>?-130,WW II 521-05-7115</b>		17. INFORMANT ADDRESS <b>RONALD J. WEEKS 3417 LIBERTY PARKWAY, 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>April 10, 1982</b> , to <b>April 12, 1982</b> , that (b) (we) lost saw the deceased alive on <b>April 12, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Ronald J. Orrell MD</b> DEGREE				22c. DATE SIGNED <b>4/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Orrell MD</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>04-15-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE V.A. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CROWNSVILLE A BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 14 1982</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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APR 14 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 3 8 7  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>YETTA ROSIN WEINSTEIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 25 1982</b>		2b. HOUR AM PM <b>9:20 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 24, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>FLORIDA</b>		13b. CITY OR TOWN <b>MIAMI BEACH</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>7735 ABBOTT AVE. #33141</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MENDEL RESNICOFF</b>		15. MOTHER'S MAIDEN NAME FIRST LAST <b>UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>264-41-1812</b>	
17. INFORMANT <b>DR. JOHN ROSIN</b>		17. ADDRESS <b>3302 W. STRATHMORE AVE. #21215</b>		17. PHONE NO. <b>#21215</b>		17. CITY OR TOWN <b>BALTIMORE</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>METASTATIC CARCINOMA</b> (c) <b>METASTATIC CARCINOMA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4-17 82</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON DC</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON DC</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-17 82</b> , to <b>4-25 82</b> , that (I) (we) lost saw the deceased alive on <b>4-25 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>John Dis...</i>		22c. DATE SIGNED <b>4/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GBMC 6701 N. CHARLES ST, TOWSON</b>		22e. ADDRESS <b>GBMC 6701 N. CHARLES ST, TOWSON</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 26, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CAPITAL HEBREW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON DC</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 28 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	

03:24:20.7 30 4

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ATTAY

[illegible]

2-11-31 7:05:11

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0...25 000 83 79.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHAM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08888			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR	
Alan Weir					April 18 82							3:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		white		Sept. 18 1913		69 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Brooklyn Pk. Md.		U.S.				Baltimore County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Arlington Baptist Nsg. Center								merchant Marines			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS					
Md.		Brooklyn Pk		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		216 E. Charles St.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
William H. Weir		Mary Doyle											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
NO		219 05 1812		Donald Weir Federalburg, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Glioblastoma Multiforme													
1919													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
22a. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1981, to April 18, 1982, that (I) (we) last saw the deceased alive on 4/18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Dr. Darold Beard		MD				4-18-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Dr. Darold Beard		11 E. Chestnut Hill Lane, Rist., Md. 21136											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE			
Burial		4/20/82		Denton Cemetery		Denton		Caroline		Md.			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles Moore		Denton Md.				APR 22 1982		James J. [Signature]					

MEDICAL CERTIFICATION

*[Faint, illegible handwriting on lined paper]*

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

8 2 0 8 8 8 9

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First Middle Last <b>A. Earl Welsh</b>		2a. DATE OF DEATH Month Day Year <b>April 22, 1982</b>		2b. HOUR <b>7: A. M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 8, 1894</b>	
6. AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Baltimore Co. Md.</b>					
10. CITY OR TOWN OF DEATH <b>Reisterstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>13112 Old Hanover Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Florist</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	
13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>13112 Old Hanover Road</b>	
14. FATHER'S NAME First Middle Last <b>Philip B. Welsh Sr.</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Virginia Frank</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-30-2257</b>		17. INFORMANT Address <b>Mrs. Ruth W. Wilson Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4380 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>82</b> , to <b>April 22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David H. Mack MD</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 22, 1982</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 26, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial</b>	
23d. LOCATION (City or Town) (County) (State) <b>Finksburg, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Eline Funeral Home Reisterstown, Md. 21136</b>			
25a. REC'D BY REGISTRAR <b>APR 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James S. Nathan</b>			

MINISTRY OF DEFENSE

No.	Name	Rank	Post	Date
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COPIES OF THIS DOCUMENT ARE TO BE DESTROYED BY THE NATIONAL ARCHIVES ON 10-1-2010

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 15 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08890

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Ruth Marie Wermuth		Female		White		Feb. 26, 1916		66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		USA		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County		Essex	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
1615 Rickenbacker Road		Housewife		Home		1615 Rickenbacker Rd.		Essex	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Benjamin P. Eggleston		Margaret B. Hein		No		212-22-0340		2729 Wegworth Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED		20. AUTOPSY?	
PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. PLACE OF INJURY		21d. LOCATION		21e. DATE REC'D. BY REGISTRAR	
		P.M. 19		STREET, FACTORY, FARM, ETC.		CITY OR TOWN		APR 27 1982	
22a. I certify that I took charge of the remains described above, held an		22b. TIME OF INJURY		22c. PLACE OF INJURY		22d. LOCATION		22e. DATE REC'D. BY REGISTRAR	
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		P.M. 19		STREET, FACTORY, FARM, ETC.		CITY OR TOWN		APR 27 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Cremation		4/26/82		Security Process		Catonsville		APR 27 1982	
24. FUNERAL DIRECTOR		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION		24e. DATE REC'D. BY REGISTRAR	
MacNabb Funeral Home		4/26/82		Security Process		Catonsville		APR 27 1982	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE		25e. DATE REC'D. BY REGISTRAR	
APR 27 1982		Thomas D. Smith, M.D.		APR 27 1982		Thomas D. Smith, M.D.		APR 27 1982	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 9 1

REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Ira F. Wheeler		2a. DATE OF DEATH April 26, 1982		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7 7 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1914 Merritt Blvd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY B.G. & E.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME William Ira Wheeler		15. MOTHER'S MAIDEN NAME Julia E.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 213-07-1547		17. INFORMANT ADDRESS 1912 Merritt Blvd Virginia L. Santmyers-Balto., MD. 21222					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. Carcinomatosis &amp; Endocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Prostatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anaemia &amp; ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-28-1982</u> to <u>4-26-1982</u> , that (I) (we) lost saw the deceased alive on <u>4-25-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Murli Mathur</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Murli Mathur, M.D.		22e. ADDRESS 1305 Fallston Rd. Fallston, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/29/1982		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home Balto. Md.		25a. DATE REC'D. BY REGISTRAR APR 27 1982		25b. REGISTRAR'S SIGNATURE <u>Murli Mathur</u>			

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APR 2 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 9 2	
1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillie Viola WHEELER						2a. DATE OF DEATH MONTH DAY YEAR April 12, 1982			2b. HOUR 6:40 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY London Fog		
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9653 Dundawan Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Maurice Waskey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Hartman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 215-05-9743		17. INFORMANT ADDRESS 9420 Twilight Dr. Janet Blucher (dghtr) Balto. 21236							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest -</i> <i>4349</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Left hemisphere infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Development of coma</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (X) (this hospital) attended the deceased from April 2, 19 82, to April 12, 19 82, that (X) (we) last saw the deceased alive on April 12, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (and I) (and I) view the body after death.											
22b. SIGNATURE <i>Jose Munoz</i>						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose Munoz MD						22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/15/82		23c. NAME OF CEMETERY OR CREMATORY St. Micheal's Luth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24. FUNERAL HOME Schimmek Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236						25a. DATE REC'D. BY REGISTRAR APR 16 1982		25b. REGISTRAR'S SIGNATURE <i>Charles J. Nathan</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 9 3 REG. NO.									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST ELIZABETH		MIDDLE C.		LAST WHITE		2a. DATE OF DEATH		MONTH 04		DAY 11		YEAR 82		2b. HOUR 8:57PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 06 <sup>TH</sup> 23 10 <sup>R</sup>		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		MD.					
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY													
14. CITY OR TOWN OF DEATH TOWSON		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER		16. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING WEEK) housewife		17. KIND OF BUSINESS OR INDUSTRY													
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY Talbot		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS "Whitecroft" R.D. 2											
14. FATHER'S NAME FIRST Albert		MIDDLE		LAST Constable		15. MOTHER'S MAIDEN NAME FIRST Emily		MIDDLE Evans		LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 199-38-4631		17. INFORMANT Richard K. White, JR.		ADDRESS Easton, MD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEPSIS/POSSIBLE PNEUMONIA</u> (c) <u>RECENT M.I.; SURGERY FOR CA.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>24 HRS.</u> <u>2 MONTHS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>M.I.; C.H.F.</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/9</u> 19 <u>82</u> , to <u>APRIL 11</u> 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>APRIL 11</u> 19 <u>82</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) (not) view the body after death.																			
22b. SIGNATURE <u>[Signature]</u> DEGREE										22c. DATE SIGNED <u>04/11/82</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BRIAN ADLER										22e. ADDRESS G.B.M.C. BALTO. MD. 6701 N. CHARLES ST.; 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-14-82				23c. NAME OF CEMETERY OR CREMATORY Stevensville Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Queen Stevensville Annes Md							
24. FUNERAL DIRECTOR NAME Newnam Funeral Home										25. DATE REC'D. BY REGISTRAR APR 19 1982									

ELIZABETH C. WHITE

REAR 05 23 10 71 YRS.

BALTIMORE COUNTY

TOWSON GREATER BALTIMORE MEDICAL CENTER

IMMEDIATE

CALIBER LIBRARY

24 HRS.

REPRODUCTION

2 MONTHS

RECENTLY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 8 9 4			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY ELIZABETH WHITE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 16, 1982</b>		2b. HOUR <b>10:55a M</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 5, 1998</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H5WE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>				13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>MIDDLE RIVER</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN SILBERSACK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA TUE SCH ECK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-12-8903</b>		17. INFORMANT ADDRESS <b>MAE TUCKER 13209 MILES RD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest; Ventricular Tachycardia</b> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 12</b> , 19 <b>82</b> , to <b>April 16</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 16</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did <input checked="" type="checkbox"/> ) view the body after death.							
22b. SIGNATURE <b>K. Yamamoto</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. YAMAMOTO</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF SAITH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>J. G. CONNELLY 300 MAE</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 8 9 5

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) PAUL JOSEPH WICKLESS, SR.			2a. DATE OF DEATH MONTH DAY YEAR 4-7-82			2b. HOUR 3:25 PM	
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 28 05		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bridgeway Manor			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Henry J. Knott	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Lansdowne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 648 5th Avenue 21227		
14 FATHER'S NAME FIRST MIDDLE LAST Joseph E. Wickless			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth H. Sadler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 213-12-8940		17. INFORMANT ADDRESS Paul Joseph Wickless, Jr. 648 5th Ave. 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOUS</u> <u>1850</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA - PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DEC 1981</u> <u>MARCH 1981</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>C.V.A. -</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 30</u> 19 <u>81</u> , to <u>APRIL 7</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>APRIL 6</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Norman R. Kleiman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman R. Kleiman, M.D.				22e. ADDRESS 3803 Edmondson Avenue			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/12/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR APR 12 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours in the files of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 8 8 9 6	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Beverly Ann Williams</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>04/ 15 82</b>		2b. HOUR <b>9:45A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 24 47</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35 34</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pittsburgh Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, County MD</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles Street</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford Co.</b>		13c. CITY OR TOWN <b>Forest Hill</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1411 Kahoe Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jerome Raymond Ruprecht</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Churilla</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>201-38-3174</b>		17. INFORMANT (Husband) <b>838-4774</b> ADDRESS <b>1411 Kahoe Road Forest Hill, Maryland 21050</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Breast Cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>03/23</b> , 19 <b>82</b> , to <b>04/15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>04/15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Brian Adler</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Brian Adler, M.D.</b>				22e. ADDRESS <b>GBMC 6701 N. Charles Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 17, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Chh. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Forest Hill, Harford Co., Maryland 21050</b>					
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>W. Broadway at Williams St.</b> <b>Bd Air, Maryland 21014</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>APR 19 1982</b>					

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1946-47  
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1947-48  
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 8 9 7					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HERBERT E. WILLS</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>04 24 82</b>				2b. HOUR <b>9 45</b> AM	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 22 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>7 2</b>		IF UNDER 24 HRS. HOURS MIN. <b>9 45</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.									
10. CITY OR TOWN OF DEATH <b>BELMONT</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>34 KETTLE COURT, 21207</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONDUCTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>							
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BELMONT</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>34 KETTLE COURT, 21207</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>NORVELL CHESTER WILLS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OCTAVIA FRANCES HOWELL</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>234-10-7836</b>		17. INFORMANT ADDRESS <b>FRANCES W. DELCHER 1001 GROVEHILL ROAD 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>After severe gastroenteritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>as</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24h</b> <b>when</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>for advanced Rheumatoid arthritis</b>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> , 19 <b>77</b> , to <b>2/18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Cliff Ratliff, Jr.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/16/82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CLIFF RATLIFF, JR., M.D.</b>				22e. ADDRESS <b>5772 WESTVIEW MALL, 21228</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>04-27-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>									

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APR 20 1984

NR21 0.2 194A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME		2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST		MONTH DAY YEAR				HOUR MIN.			
WILFRED LEIST WILSON		4/25/82				12:00 M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F	W	MONTH DAY YEAR		59 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		1408 Margarette Ave.				Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1408 Margarette Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.					
Frederick Leist		Florence Theil		219-18-1855					
17. INFORMANT		17. ADDRESS							
Donald H. Wilson, Jr.		Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Metastatic carcinoma, brain									
1991									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		1:25 P.M. 4/25/82							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		19		to		19			
saw the deceased alive on		4/24/82		1982		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
M. G. Speed M.D.		M.D.				4/25/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
William G. Speed M.D.		11 E. Chase St. Balto. Md 21202							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		4/27/82		Greenmount		Baltimore City, Maryland			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home, Inc.				6500 York Rd. Balto., Md.		APR 28 1982		James J. Harrison	

BP

0 8 3 3 3

Belmont County

Highway

1000 East Street Ave.

1000 East Street Ave.

Belmont County

Belmont County

Belmont County

Belmont County

210-18-1025 Donald A. Wilson, Jr.

No

1000 East Street Ave.

Belmont County

1000 East Street Ave.

Belmont County

Belmont County

1000 East Street Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 0 8 8 9 9 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) HELEN WINIARSKI					2a. DATE OF DEATH April 7, 1982			2b. HOUR 1:43p M			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH 1 24 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6600 Ridge Rd.			
14. FATHER'S NAME John Raczniak				15. MOTHER'S MAIDEN NAME Mary Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-16-3077		17. INFORMANT ADDRESS Stanley Winiarski 7880 Stansbury Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest; Possable Anoxic Encephalopathy</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Possable Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 4, 1982, to April 7, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 7, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.											
22b. SIGNATURE <i>Dr. Munoz</i>						DEGREE			22c. DATE SIGNED 4-7-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Munoz						22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/82		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son 2818 E. Baltimore St.						25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE <i>Anne J. North</i>		

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Case No. 100-100000-100000

Subject: [Illegible]

Date: [Illegible]

Location: [Illegible]

Reference: [Illegible]

Remarks: [Illegible]

Signature: [Illegible]

Special Agent in Charge

Federal Bureau of Investigation

U.S. Department of Justice

Washington, D.C.

200-100000-100000

100-100000-100000

100-100000-100000

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100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any retained organ.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 8203900								
1. DECEASED NAME (TYPE OR PRINT) Edward Joseph Wohrna					2a. DATE OF DEATH MONTH DAY YEAR April 20, 1982			2b. HOUR 4:40 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 30 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist		12b. KIND OF BUSINESS OR INDUSTRY Dentistry		
13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Fullerton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Woytech Wohrna					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aloisie Neybursky					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-38-5315-A		17. INFORMANT ADDRESS Shippensburg, Pa. Mrs. Dorothy W. Martin, Box 329 Rd. 6, Pineoak Lance						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4280 DUE TO, OR AS A CONSEQUENCE OF (b) Progressive congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal failure										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (X) (this hospital) attended the deceased from March 22, 1982, to April 20, 1982, that (X) (we) last saw the deceased alive on April 20, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) last (saw) (viewed) the body after death.										
22b. SIGNATURE Matthew Scott MD		DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/20/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew Scott, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-24-82		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS LASSAN F.H. 7401 BELAIR RD DATE REC'D. BY REGISTRAR 25 REGISTRAR'S SIGNATURE APR 26 1982										

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Robert A. Hart

1947-1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 8 9 0 1			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 4 17 1982			
1. DECEASED NAME FIRST MIDDLE LAST MARY O/. WOODS				2b. HOUR 8:15 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 29, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles O'Connell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Frazier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-2895		17. INFORMANT ADDRESS Joseph S. Woods, Same As #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST							
2500 } DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-22 19 82, to 4-17 19 82, that (I) (we) lost saw the deceased alive on 4-17 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Elison Brown Salters		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED April 17, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 6701 N. CHARLES ST, TOWSON MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-20-82		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR APR 19 1982		25b. REGISTRAR'S SIGNATURE Frances Jean Whithers	

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DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 9 0 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>YELTON ETHEL M.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>4-27-82</b>		2b. HOUR <b>1:05 P.M.</b>					
3. SEX <b>F.</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 4 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto Co.</b> MD.							
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Manchester</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3411 York St.</b>					
14. FATHER'S NAME <b>John</b>				15. MOTHER'S MAIDEN NAME <b>unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>No</b>							
16b. SOCIAL SECURITY NO. <b>223-22-9098</b>				17. INFORMANT <b>John H. Yelton</b> ADDRESS <b>3411 York St. Manchester, Md.</b>									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>4289</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Sever Biventricular failure with</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>degenerative pul. disease, Sepsis.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>upper C-T Bleeding.</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>4-15-1972</b> to <b>4-27-1982</b> that (I) (we) lost saw the deceased alive on <b>4-27-1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>R. M. Shah</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-27-82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. M. SHAH.</b>						22e. ADDRESS <b>1366 H. GID COURT (L) 600 RD RANDALLSTOWN MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Lutheran Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Manchester Cal. Md.</b>							
24. FUNERAL DIRECTOR <b>H. J. Eckhardt</b> <b>Manchester, Md.</b>						25. DATE REC'D. BY REGISTRAR <b>MAY 3 1982</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 9 0 3  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIRGIL H YOUNG</b> <b>VIRGIL YOUNG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-6-82</b>		2b. HOUR M <b>11:26am</b>		
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Service Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Young</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ginevra Sites</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>705-05-0086</b>		17. INFORMANT ADDRESS <b>Marianne S. Young 3207 Orlando Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4912</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A RESULT OF, (b) <b>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Chronic Obstructive Pulmonary Disease</b> (c) <b>Chronic Bronchitis and Pulmonary Emphysema</b> DUE TO, OR AS A RESULT OF, (c) <b>Chronic Bronchitis and Pulmonary Emphysema</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Gastrointestinal Bleeding</b> <b>GASTROINTESTINAL</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>3-25</b> , 19 <b>82</b> , to <b>4-6</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>4-6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Beatriz P. Dizon, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Apr. 6, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BEATRIZ P. DIZON, M.D.</b>				22e. ADDRESS <b>7620 YORK ROAD TOWSON MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 7 1982</b>			

APR 7 1965

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 9 0 4  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FLORENCE ZALKOVITZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 7 82</b>		2b. HOUR <b>5:45 AM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 28, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5819A WESTERN RUN DR. #21209</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES ZALKOVITZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE GOODMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-28-4437</b>		17. INFORMANT <b>MRS. KATHERINE FRIEDMANN</b> <b>3916 NOYES CIR., APT. 104 RANDALLSTOWN, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <b>/</b> DOE TO, OR AS A CONSEQUENCE OF (c) <b>/</b>						21133 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PREVIOUS MYOCARDIAL INFARCTION, PERIPHERAL VASCULAR DISEASE</b>									
19a. DATE OF OPERATION <b>8/3/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>4/3/82</b> to <b>4/7/82</b> , that (we) last saw the deceased alive on <b>4/7/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Akhil Kumar Chopra</b>				DEGREE <b>MBBS</b>		22c. DATE SIGNED <b>4/7/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A-K CHOPRA</b>				22e. ADDRESS <b>BALTIMORE COUNTY GEN. HOSPITAL RANDALLSTOWN MD 21133</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 11, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 15 1982</b>					
6010 REISTERSTOWN RD. BALTO., MD 21215				25b. REGISTRAR'S SIGNATURE <b>Frances Jean Katten</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 9 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Joseph J. ZARKI			April 2, 1982			7:45 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	8-15-1888	93 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Lithuania	U.S.A.		Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Franklin Square Hospital		Bethlehem Steel			Retired		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Md.			Balto.			4600 Forest View Ave.-21206		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
John Zarki			Barbara					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			213-07-8189			Mary A. Zarki -4600 Forest View Ave.-21206		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 0417								
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized pseudomonas infection								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Pneumonia								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE				
22a. I certify that X (this hospital) attended the deceased from February 5, 19 82, to April 2, 19 82, that (we) last saw the deceased alive on April 2, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (we) (and) (and) saw the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Michael Gosney						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		4/2/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Michael Gosney						9000 Franklin Square Dr., 21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		4-5-82		Holy Redeemer Cem.		Balto. Md. COUNTY STATE		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		
John C. Miller Inc-6415 Belair Rd.-21206						APR 5 1982		
						REGISTRAR'S SIGNATURE		
						Francis J. Smith		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 9 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary A ZARKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1982</b>		2b. HOUR <b>2:28 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-28-1898</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lithuania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS <b>83</b>		
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam Savickas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-12-1435</b>		17. INFORMANT ADDRESS <b>Mrs. Helen A. Silanskas 4600 Forest View Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Electromechanical disassociation</b> (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Bilateral pneumonia with atelectasis of the left lower lobe</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from <b>April 18 19 82</b> , to <b>April 22 19 82</b> , that (X) (we) last saw the deceased alive on <b>April 22 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Michael Gosney MD</b>				22c. DATE SIGNED <b>4/22/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Gosney, MD</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-24-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 28 1982</b>		
				25b. REGISTRAR'S SIGNATURE <b>James Van Natten</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.2  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO 08907

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret C. Zech			2a. DATE OF DEATH MONTH DAY YEAR 04/ 06/82			2b. HOUR 7:40A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 18, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Balto. Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR	
12b. KIND OF BUSINESS OR INDUSTRY BOX FACTORY		13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5805 HILLEN RD. APT. B		14. FATHER'S NAME FIRST MIDDLE LAST JAMES HENRY McDERMOTT			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA P. HARTZELL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-22-3860A		17. INFORMANT ADDRESS RECORDS MASONIC HOMES OF MD. COCKEYSVILLE MD.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4289 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>04/01</u> , 19 <u>82</u> , to <u>04/05</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>04/06</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE GARY R. GAFFNEY, M.D. 22c. DATE SIGNED 6-Apr-82				22d. ADDRESS GBMC 6701 N. Charles Street	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PK.	
23d. LOCATION CITY OR TOWN TOWSON		23e. COUNTY BALTIMORE		23f. STATE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212				25a. DATE REC'D. BY REGISTRAR APR 8 1982	

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